

Report on the
SPECIAL EVALUATION OF THE
MOH URBAN HEALTH DELIVERY SYSTEMS PROJECT
(UHDP)

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EXECUTIVE SUMMARY

The purpose of this evaluation was to review the Urban Health Delivery Systems Project (UHDP) in terms of its impact on achieving its stated purpose, and to determine whether or not resources available to the project were being used to its maximum benefit.

The UHDP was designed "to make the existing urban health care delivery systems more accessible and effective so that it better supports efforts at health improvement in the project area, and could form the basis for Cairo-wide and other urban area replications." Its major thrust is "to upgrade and modify the existing maternal and child health and family planning delivery system."

To accomplish this purpose, AID is providing the Government of Egypt \$37.3 million through November 1986 for this \$117.8 million project (with the remainder provided by the GOE). The AID funding supports: (i) technical assistance (ii) architectural and engineering services; (iii) renovation and construction of facilities; (iv) commodity inputs; (v) participant and in-country training; and (vi) other costs such as feasibility studies and innovative interventions (e.g. support to Health Insurance Organization activities). The project activities are directed to a target group of approximately 2,500,000 women and children in five zones in Cairo and in the four zones of Alexandria.

Construction, or renovation and equipping of facilities have clearly been the main focus of the project thus far both in terms of resource allocation (over 70% of AID's input to the project) and actual implementation emphasis. However, the Project also has other components that potentially could be more important in terms of health benefits.

It appears that with a few recommended changes, the construction and renovation of Maternal and Child Health Centers, General Urban Health Centers, and the Center for Social and Preventive Medicine, will be completed by the end of the Project. Those project components which would have been likely to have had significant effects on services and their acceptance have been allowed to lag behind, while the project focused on construction and renovation efforts. It now seems unlikely that many of the centers will be providing significantly increased volume or improved quality of services to the target population, or that there will be improvements in the types, quantities, quality and public acceptance of maternal and child health services provided by the MOH. Furthermore, the present organizational and administrative location of the Cairo portion of the project within the MOH seems unlikely to lead to any MOH institutionalization of capability to carry out additional efforts of this type. A more appropriate location for such an organization would be under the direct control of the Governorate Undersecretary for Health. This is now being tested in Alexandria with seemingly good results.

Nevertheless, it should be emphasized that the project can still largely succeed in delivering certain of its intended outputs. Over 70% of project expenditures are related to construction, renovation and equipment. These have a high probability of being delivered by the project completion date if evaluation recommendations are accepted.

8

The Evaluation Team recommends that USAID assistance to the project continue. The facilities constructed will constitute a visible sign of USAID's attempts to help Egypt in the health sector. There is also still some chance that service improvement components of the project might lead to changes in health services (even if only within the facilities involved in the project) and possibly to improved health for some users of those services.

Specific additional recommendations made by the evaluation team relate primarily to: (i) reorganization of the project (e.g., the project should be managed as several related but relatively independent subprojects; the project's central office should be reorganized); (ii) reemphasis of certain project priorities (e.g., strengthening of the service improvement aspects of the project); (iii) and innovative approaches to overcome insufficient operating budgets available for facilities (e.g., the institution of "Economic Clinics" within the project).

Table of Contents

	Page No.
Executive Summary	i
Table of Contents	iii
List of Figures and Annexes	iv
List of Acronyms and Abbreviations	v
1. Introduction	1
2. Summary Description of the Project as Designed and Formally Amended	2
3. Project Disbursement History	6
4. Implementation Progress and Obstacles Encountered	8
4.1 Project Organization and Management	8
4.2 Cairo MOH Activities and Inputs	11
4.2.1 Cairo MOH Construction, Renovation, and Equipment	11
4.2.2 Cairo MOH Service Improvement, Training, & T.A.	13
4.3 Alexandria MOH Activities and Inputs	15
4.4 Innovative Activities	16
4.5 Alexandria HIO Inputs and Activities (Equipment, Training, & T.A.)	16
4.6 USAID Management and Monitoring/Evaluation of Project	16
5. Critical Review of UHDP Background, Design and Issues	17
5.1 Critical Review of UHDP Background, and Design	17
5.2 Project Issues	20
5.3 Likely Future Course of Project	21
6. The UHDP in the Context of the 1982 Health Sector Assessment and Draft USAID Health Sector Strategy	23
7. Feasible Approaches to Overcoming Implementation Obstacles of UHDP	24
8. Recommendations	26

LIST OF FIGURES

Figure 1	Structure of Project Activities and Budget	5
Figure 2	Disbursement History and "Pipeline" of UHDP	7

ANNEXES

- A. Scope of Work for the Special Evaluation of the UHDP, Aug-Sep 1982
- B. Principal List of Reference Materials Used by the Special Evaluation Team
- C. Key Persons Contacted by the Special Evaluation Team
- D. USAID Engineer's Review of Engineering and Construction Contracting and Renovation/Construction Aspects of the UHDP: Mr. Robert Cook
- E. Medical Anthropologist Review of Social Science Aspects of Project: .
Dr. Nawal El-Messiri Nadim
- F. Action Timetable and Responsibilities
 - For USAID Action
 - For UHDP Action
- G. Notes for Team Evaluating the CSPM

LIST OF ACRONYMS AND ABBREVIATIONS USED IN THIS REPORT

A & E	Architectural and Engineering
CSPM	Center for Social and Preventive Medicine at Cairo University School of Medicine
ECTOR	Experimental Center for Training on Evaluation of Social Programs
GOE	Government of Egypt
GUHC	General Urban Health Centers of the Ministry of Health
HIO	Health Insurance Organization, Alexandria
MCH	Maternal and Child Health
MOH	Ministry of Health, Arab Republic of Egypt
ORT	Oral Rehydration Therapy for Treatment of Diarrheas
RFTP	Request for Technical Proposals
TA	Technical Assistance
UHDP	Urban Health Delivery Systems Project of the Arab Republic of Egypt, with funding provided by the Agency for International Development
USAID (AID)	Agency for International Development of the United States Government

1. Introduction

The Scope of Work (Annex A) for this Special Evaluation of the Urban Health Delivery Systems Project (UHDP) called for the Evaluation Team to:

"...review the project in terms of its impact on achieving its stated purpose 'to make the existing urban health care system more accessible and effective'; and to determine whether or not resources available to the project are being used to the maximum benefit of the project. The team will also consider changes in the project design and in the implementation schedule contained in the Project Paper which would clearly improve implementation of the project through its completion date (November 1986)."

This is the first major external evaluation of the Urban Health Delivery System Project (UHDP), a \$117.8 million (\$37.3 from AID with remainder coming from the GOE) "demonstration" project authorized in November of 1978. AID assistance under the project is scheduled to end in November of 1986. An internal review of the project, that served as a starting point for this evaluation, was carried out in May 1982 by the Project's central office (MOH) staff and by staff from the technical assistance contractor (Westinghouse).

The present potential of the UHDP can be summarized as follows:

- The construction, renovation and equipment components of the UHDP are likely to be completed by the end of the project, in spite of delays, if the Evaluation Team's recommendations are followed. The main problems of concern now relate to the possibility that construction and renovation activities may have broken MOH leases for some of the properties.
- Service improvement aspects of the UHDP have been neglected, relative to the staff's efforts to initiate and manage construction and renovation
- Given the Project's complicated and ambitious design and the course of its implementation thus far, it appears unlikely that the Project will make any major contributions to the goal of improving health status even in the target populations. It also appears unlikely that it will improve the types, quantities, quality and public acceptance of MOH services provided by the MOH, even in the new or renovated facilities which will have consumed most of the Project's resources.
- Nevertheless, the Evaluation Team recommends that AID assistance to the Urban Health Delivery Systems Project should continue, primarily because the facilities constructed and renovated may become one of the few visible signs of AID's attempts to help Egypt in the health sector. Continuation is also recommended because there is still some chance that other parts of the project might lead to changes in health services (even if only within the facilities involved in the Project) and possibly even to improved health for some users of those services.

2. Summary Description of Project as Designed and Formally Amended

The goal of the Urban Health Delivery System Project (AID Grant 263-0065) is "to improve the general health of the Egyptian people." The purpose of the project is "to make the existing urban health care delivery system more accessible and effective so that it better supports efforts at health improvement in the project area and could form the basis for Cairo-wide and other urban area replications." The strategy of the project is "to modify the current marginally functioning health delivery system and to improve the delivery of health, nutrition and family planning services to low-income families in the project area."

The UHDP was "planned as a demonstration effort [originally limited to three health zones of the Cairo Governorate] designed to make the urban health system more accessible and effective." It stated "major thrust [was] to upgrade and modify the existing maternal child health and family planning delivery system." The project set out "to correct the major problems in the current delivery system." These problems were identified as:

- "- Fragmentation of services (as many as six health service delivery systems are represented in some areas).
- Poor distribution of personnel resources.
- Poorly maintained and deteriorated physical facilities.
- Low public acceptance and utilization of peripheral health care units.
- Poor control and management of the system.
- Lack of motivation and skills on the part of health personnel and lack of practical experience available to them within the medical education system.
- Inadequate outreach of health services from clinics."

The project intended "to correct the major problems in the current delivery system" by:

- " - Developing within the MOH the capability to perform on a continuing basis, assessments of the health sector designed to provide the data and information required to plan, implement and evaluate delivery of health services which are more relevant to the needs of consumers.
- Establishing and testing of a pyramidal system of health delivery and referral that will involve local Maternal Child Health Clinics (MCH's), General Urban Health Centers (GUHC's) and a specialty pediatric hospital.

- Establishing within Cairo University Pediatric Hospital a Center for Social and Preventive Medicine in order to bring together the medical teaching and service delivery functions of the university with the health delivery responsibility of the Ministry of Health.
- Training and educating health service providers in order to upgrade the services they deliver.
- Developing community participation, motivation and health services outreach.
- Other activities, such as conducting feasibility studies and introducing low-cost innovations to improve the delivery of health services."

To accomplish the above, AID provided \$ 25.272 million in a grant agreement signed November 1978 to fund: (i) technical assistance, (ii) architectural and engineering services, (iii) renovation and construction of facilities, (iv) commodity inputs, (v) participant and in-country training, and (vi) other costs such as feasibility studies, innovative interventions and IEC activities.

The project grant agreement was subsequently amended in September 1979 to add two additional zones of the Cairo Governorate for the purpose of renovating and equipping of MCH centers, with no addition to funding. The project grant agreement was then amended a second time in August 1981, adding \$12.0 million, bringing the total project budget to \$37.253 million, and extending the completion date to November 1986. The additional funds were allocated to finance estimated cost increases in the original project as amended in 1979 and to finance expansion of project activities to Alexandria and the addition of a new project component for innovative activities (to support the project purpose, but not necessarily within the formal MOH system). Project activities in Alexandria were limited to the establishment of a small project office, renovation and equipping of MCH centers in the metropolitan area, and a small amount of technical assistance and training. Of the innovative activities budget of \$2.5 million, \$1.5 million was "expected" to be requested (and later was) by the Health Insurance Organization (HIO) in Alexandria to establish a computerized information system. A summary of the several related, but relatively independent, parts of the Project are shown in Figure 1.

Thus, while the goal and purpose of the UHDP remained unchanged, project geographical coverage expanded considerably under the two amendments, increasing from three health zones to five zones in Cairo plus the four zones in Alexandria. The expansion of the project was not uniform in terms of original design, being limited solely in Cairo and primarily in Alexandria to renovating and equipping MCH centers. However, nominal (unplanned) provisions were made in the grant agreement to replicate in these added zones instructional materials, training and protocols that test out satisfactorily in the original project area.

The composition of the major components of the project as currently amended, consists of: (i) renovation (22 MCH centers and one pilot GUHC center in Cairo plus 11 MCH centers in Alexandria), (ii) construction (8 GUHC's, and 1 CSPM, all in Cairo), (iii) commodities and equipment (for all of the above construction and renovation but largely for the 8 GUHC's, the CSPM and the HIO information system included under innovative activities), (iv) training (in country and out of country), (v) technical assistance (U.S. and Egyptian, primarily in support of the development, testing, implementation and institutionalization of envisioned health service improvements and interventions), and (vi) innovative activities (to support improvements in the urban delivery system as a whole, including entities outside the formal MOH system such as the HIO).

FIGURE 1

STRUCTURE OF PROJECT ACTIVITIES AND BUDGET *
(Millions)

	CAIRO MOH		ALEX MOH		ALEX HIO
A&E	: A&E	2.0)	: A&E	.2	:
Construction	: 8 GUHC	4.4) 11.6	:	:	:
	: 1 CSPM	5.2) 14.8	:	:	:
	:)	:	:	:
Renovation	: 22 MCH)	: 11 MCH	1.7	:
	: 1 Pilot Clinic) 3.2	:	:	:
	:)	:	:	:
Equipment	: For Facilities	6.8	: For Facilities	.9	:
	:	21.6	:	2.8	: Computer:
	:	(58.1%)	:	(7.5%)	:
	:	:	:	:	:
	: T.A.	5.6	: T.A.	.2	: Computer
Service Improvement	: Training	1.1	: Training	.1	: Software + T.A.:
	:	6.7	:	.3	:
	:	(18.0%)	:	(0.8%)	:
	:	:	:	:	:
		TOTAL		TOTAL	
		28.3		3.1	1.5
		(76.1%)		(8.3%)	(4.0%)

Currently programmed above 32.9 (88.5%)
 Contingencies 3.3 (8.6%)
 Innovative activities 1.0 (2.7%)

* AID contributions only.

17

3. Project Disbursement History

Figure 2 on page 7, displays the record of UHDP disbursements and accruals to September 30, 1982.

Delays in implementing the renovation, construction and equipment components of the project have resulted in an overall low percentage of project disbursements against that planned. This is particularly true with new construction and equipment procurement which must be closely coordinated with the design work for the CSPM and GUHC's. Since initial A&E contract problems with DMJM/Kidde have now been overcome, it is expected that the most of these funds will be disbursed over the next 24-36 months. Renovation of the Cairo MCH centers has been delayed for a variety of reasons as documented in Annex D. The relative disbursement record for renovations should improve if Evaluation Team recommendations are followed.

The Alexandria UHDP activity also shows a very low percentage of disbursement. This is because implementation of the renovation work was delayed by the decision of AID and the Project Director to open competition to all US and Egyptian firms. Actual renovation contracts should be finalized by 9/83. Expenditures for this activity thus far have been in support of local training and the Alexandria project office. Considered alone, those two components are on schedule.

The HIO (an "innovative activity") to date has been unable to draft a Request for Technical Proposal (RFTP) for technical assistance and computer equipment that is acceptable to AID. Therefore, no funds have been disbursed for that activity. The RFTP, however, should be finalized by February 1983.

No disbursements have been made for other "innovative activities" due to the lack of proposals. The evaluation team has identified two possible activities (support to ECTOR and Alexandria MOH service improvements) that might be funded from this budget line item. It should be noted that no "advertisement" of the availability of this money has been made, nor is it recommended for the future. This special budget line item is discussed in more detail in other parts of this report.

FIGURE 2

DISBURSEMENT HISTORY OF UHDP
To September 30, 1982
(\$000)

	Disbursements/ Accruals to September 30 Actual	Planned	A/P%	LOP Budget	% LOP Disbursed/ Accrued to 30SEPS2
<u>Technical Assistance</u>					
Westinghouse Contract	1,574	1,700	93%	3,562	44%
<u>Budget Support to Project Office *</u>	473	477	99%	1,500	32%
<u>Renovation of MCH/Pilot Centers</u>					
Alemara A&E	140	157	89%	157	89%
Egyptian Const. Firms	1,000	2,500	40%	3,023	33%
<u>New Construction</u>					
GUHC's (DMJM/Kidde)	624	3,293	19%	5,493	11%
CSPM (DMJM/Kidde)	100	3,500	3%	6,300	2%
<u>Equipment & Vehicles</u>	167	4,250	4%	6,797	2%
<u>Training</u>	409	490	83%	1,155	35%
<u>Health Sector Assessment</u>					
ECTOR	317	327	97%	327	97%
<u>Alexandria UHDSF</u>	28	2,775	1%	3,140	1%
<u>HIO</u>	0	1,500	0%	1,500	0%
<u>Other "innovative activities"</u>	0	1,000	0%	1,000	0%
TOTAL	4,832	21,969	22%	33,954 ^①	14%

* Includes funds for Egyptian Consultants, local training, pilot center (other than renovation), office support and health education activities.

① Does not include contingencies which make AID's total LOP funding \$37.253 million.

4. Implementation Progress and Obstacles Encountered

4.1 Project Organization and Management

4.1.1 Project Organization

The UHDP has been organized basically within the framework foreseen in the Project Paper and related documents. However, the project's organizational structure has lent itself to the implementation of a centralized pattern of administration (common to GOE Ministries) within the UHDP central office. That pattern has some unfortunate effects upon the project, as described below under "project management".

There are two organizations responsible for the management of this project on the GOE side. The first is the Project Executive Board chaired by the First Undersecretary of the MOH. The Board membership consists of representatives from the Cairo Governorate, Alexandria Governorate (recently added), the HIO, Cairo University Faculty of Medicine, Ministry of Social Affairs and resident (non-MOH) representatives from three of the five Zones in Cairo. The Board is charged with the responsibility for establishing policy, coordinating activities between agencies and overall management of the Project.

The second organizational structure is the UHDP Project Office responsible for the day-to-day management of the Project. The Project Office is headed by an Executive Project Director who is also the Executive Secretary for the Executive Board. Organizational units supporting the project, and for which the Executive Project Director is responsible, include Organization and Management, Research and Development, Training, Health Education and Social Work, Statistics and Evaluation, and Administration and Finance. Other support to the Executive Director is provided by Egyptian and expatriate contractors and consultants in such specialties as public health, health planning, training, construction, equipment procurement, finance, law and public relations. The General Directors of the Health Zones involved in the project (with the exception of Alexandria) are designated as Assistant Executive Project Directors, but have no direct command link with the project.

The Project Office and the Executive Board are considered to be temporary. These organizations are not meant to be the implementors of the project, but are meant to be the planners and advisors to the existing MOH staff who are intended to carry out the project at the Governorate and Zone levels. Each of the Health Zones has designated a member of their staff to be responsible, on a regular basis, for project activities in their respective Zones. Coordination is effected through regular joint meetings between Project and Zone staff (at least monthly).

The Project Office in Alexandria consists of a Project Director and individuals to handle interventions, training, procurement, accounting and secretarial support. Unlike Cairo, the Project Director is under the control of the Undersecretary of State for Health (who is an Executive Board member) rather than being under the direct control of the Executive Board. Like Cairo, however, the Alexandria Project Office is also considered to be temporary (i.e. for the life of the Project). Part-time consultants and contractors are also available to the Project Director as needed.

As mentioned, both Cairo and Alexandria are making use of contractors to provide advice and assistance in furtherance of project activities. In Cairo the Executive Project Director has contracts (host country type) with Westinghouse Health Systems (technical assistance and equipment procurement), ECTOR (Cairo health assessment study), Alemara (for A&E and supervision of MCH centers' renovation, and renovation of the Tora Pilot GUHC), DMJM/KIDDE (for A&E and supervision of the CSPM and GUHC's) and four construction contractors (for MCH center renovations). In Alexandria the Project Director has contracted for the services of one, part-time American advisor (Robert Emery) who is providing general technical assistance to the Director. In all cases, contractors are under the direct control of either the Executive Project Director for Cairo, or the Project Director for Alexandria.

The special evaluation team feels that the project has components which need to be considered as major entities, but which are not given adequate emphasis within the present organizational structure of the project. For example, the Alexandria UHDP activities are said to have a high degree of independence yet incentive payments must be individually approved by the UHDP Project Executive Director in Cairo. Placing service improvement activities and construction, renovation, and equipment under the responsibility of the same person within a centralized structure virtually guarantees inadequate attention to service improvement, given the MCH's enthusiasm for buildings.

In both Cairo and Alexandria, the organization charts for the project are somewhat misleading, because some of the staff members who appear on them are seldom at work on the projects. This is due mainly to the fact that they also hold other full-time jobs in the Government.

By not supplying active MOH counterparts in the Urban Health Sector Assessment which ECTOR carried out under the project, the MOH lost an opportunity to greatly increase the skills of some of its own personnel in data gathering, analysis, interpretation, and use in planning and decision making.

Renovation efforts under the Cairo UHDP (See USAID Engineer's report, Annex D) appear to have suffered delays due to conflicts between two parties involved in an adversary relationship which is partly attributable to overlapping scopes of work and conflicting roles.

The organizational and administrative location of the project within the MOH seems unlikely to lead to any MOH institutionalization of capability to carry out project activities. The special project office, operated by staff on secondment from other MOH units and paid high salary supplements in their project roles, is most unlikely to outlast AID support of the UHDP.

Capabilities present or being developed within the project's central office staff seem unlikely to be transmitted to Zone and Governorate level counterparts, because counterpart relations have not been effectively established on a regular working basis. The dichotomy between planning (special project staff) and implementation (regular MOH Governorate, Zone and clinic director hierarchy) threatens both present implementation of health service related activities and any institutionalization of planning capabilities in the Governorate or Zone staff. At the same time, it appears that thus far most UHDP activities are carried out by the central office staff, with regular MOH staff participation consisting primarily of attending meetings.

4.1.2 Project Management

Management of the UHDP is made difficult by problems of the Egyptian administrative environment and particularly of the GOE. The highly centralized administration of the project office and the lack of effective delegation of authority and responsibility hamper progress in the project. This is especially true for progress in areas which do not rank high in the personal interests of the project's directors. Overcontrol of decision making causes sluggish performance by project office units and undercuts authority which unit directors might otherwise exercise.

By a reportedly unique ministerial decree, the UHDP Executive Director was given funds to use at her discretion to provide incentive payments to persons working for the project and for others whose cooperation or work could advance the project. The decree is said to establish ranges for monthly incentives in terms of base MOH salaries: 50 to 100% of base salary for part-time UHDP work, and 100 to 150% for full time UHDP work. Additional incentive payments may also be made, to project personnel and others, apparently with no upper limit within the overall incentive budget. Monthly "incentive" payments appear to be made to essentially all project staff members, essentially as salary supplements granted for joining the UHDP staff and with little attention to performance. This vitiates the usefulness of incentive payments as means of promoting and rewarding good performance.

Certain MOH staff at the Zone offices also receive regular incentive payments. Special incentive payments are made to various persons involved in the project or in positions to make decisions with regard to it.

In addition to monetary incentives, training and observational travel can function as rewards for good work. Unfortunately, a disproportionate number of observational trips have been taken by senior MOH officials.

Relatively few incentives are available to non-project MOH personnel who should actually implement the service changes to be effected under the UHDP. This problem has not been dealt with by the project and is likely to eventually have severe impact on project implementation of health service related activities.

Little has been done within the UHDP in the way of development and application of basic project management tools. No means of readily tracking work progress are available, although they are clearly needed in such a complex project. Coordination among the various units of the UHDP office in Cairo seems to be weak. Rational sequencing of work seems lacking. Serious service improvement efforts tend to be delayed until facility renovations are complete. Procurement of equipment has lagged so far behind renovations that some facilities will have to open with only partial equipment. For GUHC's, even offshore procurement requiring very long lead times will apparently not begin until all equipment for MCH's has been obtained, and CSPM equipment will not be ordered until the GUHC equipment has been procured.

4.2 Cairo MOH Activities and Inputs

4.2.1 Cairo MOH Construction/Renovation/Equipment

Funds are provided in the Project for the construction of 8 General Urban Health Centers. These GUHC's are second level health care facilities generally providing all the functions of health bureaus (public health, school health, etc.), MCH centers and curative care at the general practice physician level. Supportive services (e.g. laboratory support) are also provided in the GUHC's. Each center is meant to serve a population of approximately 150,000 persons.

Each 1400 square meter GUHC is expected to cost \$687,000 including the required design and construction supervision work. At the present time, the A&E contractor (DMJM/KIDDE) is preparing final drawings and specifications for the buildings from preliminary drawings prepared earlier in the year. Current projections are for these plans to be finalized in late Spring 1983, with actual construction to start in the Fall. Completion time will be 12-18 months after start of construction.

The Tora Pilot GUHC is presently being renovated (at a cost of \$43,000) and is scheduled to begin full operation in November 1982. Funds were provided for this work so that project staff could have with a "testing" facility for service improvement efforts while construction efforts were underway on the other GUHC's.

The GUHC construction component of the project is approximately 12 months behind schedule. Most of the delay is related to problems in the early stages with the A&E contractor who submitted preliminary plans and specifications for the GUHC's which were not within the space size (1400 square meters) and budget set by the Project. Extensive redesign was required as a result. This was made particularly difficult since the architect's duty post was in the United States (subsequently corrected).

Construction, at an estimated cost of \$6.3 million (including A&E), of the multi-purpose Center for Social and Preventive Medicine (6 floors with about 7200 square meters of floor space) is also about 12 months behind schedule. The A&E firm, again DMJM/KIDDE, is presently preparing the preliminary report for the construction which should be finalized in December 1982. Actual construction work is scheduled to begin in August 1983 and end approximately 18-24 months later (i.e., between March and September 1985).

The status of renovation work for the 22 Maternal Child Health centers is well covered in the report prepared by the USAID engineer who participated in this evaluation (Annex D). Four of the centers should be reopened in November 1982. However, it is difficult to predict at this time when the work at the other 18 centers will be completed since it appears that some of the construction contracts will have to be amended to take into consideration the findings of the USAID engineer. Until this is done, and contracts renegotiated, accurate estimates of completion dates can not be made.

The majority of the \$6.8 million set-aside for commodities in the Project will be used to purchase equipment for the GUHC's and the CSPM. Funds will also be used to purchase equipment for the MCH's; however, it is anticipated that most of the equipment needed for these facilities will be available on the Egyptian market. Unfortunately, planning for the equipment purchases has been left almost entirely in the hands of an expatriate contract advisor who up to this time has had no counterpart with whom to work. He has also been hampered by not having final drawings and specifications for the facilities construction which are required to plan equipment needs. The Executive Project Director informed the team that a counterpart committee was being formed by the MOH to work with the expatriate advisor. She expects that a decree establishing this working group will be signed within the next 30-45 days. Unfortunately, it now appears that some of the MCH centers will be reopening some without the required equipment and supplies on hand.

A long outstanding issue concerning project commodities relates to a March 1981 Auditor General Audit Report covering the Project. The AG felt some of the vehicles (12) purchased by the Project were not needed based on the usage that they observed at the time. They also felt that the vehicle being used by the First Undersecretary of Health (also Chairman of the Project Executive Board) should be returned to the Project staff since it was not being used exclusively for the Project. Both of these issues remained outstanding at the time of the evaluation. An end-use check was therefore made by the Project Officer with the determination that, based on usage, the 11 vehicles assigned to the Project staff were, in fact, needed. An official request was also made by the Mission Deputy Director to the First Undersecretary of Health that he return the 1 vehicle to the Executive Project Director, or alternatively refund its cost to the Project. This last matter was still pending at the time the Evaluation Report was finalized.

4.2.2. Cairo MOH Service Improvement, Training, and Technical Assistance

The special evaluation team finds that up to the time of this evaluation there has been no noticeable improvement in health services as a result of UHDP efforts. This is in part because the UHDP project team is waiting for facility renovations to be completed before attempting to improve services. This approach has cost the project valuable experience which it will have little time to regain once the renovations are complete.

Project staff (including advisors and consultants) have developed a set of interventions which they feel will improve services and at the same time will be replicable in MCH facilities. These interventions include improved oral rehydration therapy, use of growth charts, bacterial sterilization, drug packaging and outreach. The interventions designed are intended to be usable in both MCH Centers and GUHC's, but will first be tested at the Tora Pilot GUHC.

The GUHC at Tora (Helwan) was selected for the pilot effort because it needed a minimum of renovation to bring it up to an acceptable level, had strong community backing and had motivated staff who were willing to take on the extra work necessary to test the interventions.

The intervention packages appear to be ready for testing, having been refined with the assistance of expatriate advisors during the renovation period. However, more attention to the actual procedures for evaluating the interventions appears to be needed. This question is now under study and will be further pursued following the pilot center opening in November 1982.

Training programs in Egypt were one of the first elements of the Project to be initiated. To date, courses have been held for approximately 2,000 persons drawn from all levels of the MOH and other organizations related to the Project. Subjects covered have included health planning, health service research, management of health services, family planning, orientation to urban health services, professional education for physicians and others, outreach, health educator and housekeeping.

Nevertheless, according to results of the ECTOR Urban Health Sector Assessment, only 46 of the 356 MOH staff interviewed had received formal training in the past 5 years from all sources. Only 91 of the staff were currently involved in continuing education and only 27 of these were receiving job-related training. This finding is difficult to reconcile since extensive training has taken place under the project. Turnover of personnel in MCH's and GUHC's may be a partial explanation of this discrepancy.

The training carried out under the project has apparently been cognitively oriented, not skills focused, and not especially targeted toward specific job responsibilities. It has also not involved on-the-job observations or followup testing to determine whether trainees could later perform the tasks which their jobs require in the area of the training they had received.

To date \$409,000 has been spent on out-of-country training for 1 long-term (over one year) and 65 short-term participants in skills ranging from family planning to epidemiology. It appears that training assignments are for the most part being made on the basis of need and merit, especially for academic type training. The team was concerned, however, that observation tours are being used almost exclusively by senior project and project related staff. Further observation tours should be assigned primarily to mid-level officials within the regular implementation hierarchy on a non-repetitive basis. The responsibility for preparing justification for observation tours should rest with the Project Executive Director.

The principal technical assistance contractor for the Project is Westinghouse Health Systems (WHS). Currently, there are three persons assigned to Egypt to support the Project Executive Director and her staff. These are a Public Health Physician, an Equipment Specialist and an Administrative Assistant. In addition to these long-term staff, WHS also brings to Egypt various short-term consultants as requested by the Executive Director to assist in planning aspects of the Project for which outside expertise is deemed necessary. Recent expertise was provided in health education, program planning and evaluation, and university, community programs. The present Chief of Party for the WHS contract arrived in Egypt in May of this year. The Evaluation Team was impressed with his efforts thus far to push service improvements to the forefront of project activities. He has the cooperation of Egyptian staff and should be able to develop his ideas in a short period of time. The new project implementation schedule that WHS is developing for the Project, as called for in their contract, will be revised to take these new ideas into account.

The project's Urban Health Sector Assessment effort was conducted under UHDP contract by Egypt's Experimental Center for Training on Evaluation of Social Programs (ECTOR). It was intended to foster data gathering, analysis and systems planning capability in the MOH (in addition to providing information for use in improving MCH services in Cairo). While ECTOR has developed the necessary methodology, there is no evidence that

the MOH has institutionalized this capability. Lack of such capabilities could effectively close-off the possibility of major improvements in MOH urban services. Unless major changes are made in the present MOH's information development and planning capability, improvements in health services probably will not occur. Project funds could be used (see Section 4.4) to help ECTOR keep the capabilities it has developed available to the MOH and to other health sector agencies, and to help ECTOR scientifically meet the felt information needs of selected health sector decision makers. This may be the only available means of stimulating the growth of demand for health planning information (as opposed to donors' simply demanding that such information be gathered and then paying for it). Such an investment of UHDP funds could have benefits beyond the UHDP and beyond the MOH.

4.3 Alexandria MOH Activities and Inputs

Activities in Alexandria began in the last quarter of 1981. At present, training is being conducted and programs are being developed for implementation in that location. One Egyptian consultant (also connected with the Cairo program) and one U.S. contractor are advising the Project Director in program planning and direction and are helping her to coordinate activities with work in Cairo. The Evaluation Team strongly feels that Alexandria should not be put in a position of having to wait for results of Cairo testing before moving ahead with service improvement activities of their own. If Alexandria feels that other interventions (beside those to be tested in Cairo) might be of more value to them, they should be encouraged to move ahead with them. For the short term, the Project staff should begin planning activities for services that will be performed by staff of the MCH centers that will soon be temporarily closed for renovation work.

Funds are provided in the Project for the renovation of 11 MCH centers in Alexandria, along with the equipment necessary for upgrading the centers. At the present time, the Project Staff is preparing to issue a Request for Proposals to obtain the services of an A&E firm for the design and supervision of this work. It is estimated that a contract will be signed by Spring of 1983 with actual renovation work to start 6-8 months later. Prior to signing any renovation contracts, however, Alexandria will need to insure there are no legal barriers to the actual renovation work, especially in the four leased buildings.

4.4 Innovative Activities

Funds (\$2.5 million) for innovative activities were set aside in Amendment No. 2 of the Project Paper "to support improvements in the urban health delivery system as a whole, including entities outside the formal MOH system, through the study, support and replication of activities which have shown promise for improving accessibility and quality of services for the poor." One such innovative activity for which funds have been set-aside is support to the HIO for computer hardware, software and related technical assistance (\$1.5 million). The team has identified two additional programs that appear to be appropriate "innovative activities": support to the Alexandria UHDP for improving health services and to ECTOR for health strategy formulation and planning and for health services research.

4.5 Alexandria Health Insurance Organization Inputs and Activities

The HIO in Alexandria has been working for approximately four years to plan a computerized management information system for its internal operations. Under Project Paper Amendment No. 2, \$1.5 million was made available to help equip and develop that system. However, the HIO has not yet completed the descriptive documents needed for AID processing and consideration. An RFTP is expected to be finalized by February 1983.

4.6 USAID Management and Monitoring of the Project

AID currently monitors this project with a staff Project Officer. This person is responsible for all aspects of the Project, from meeting AID's fiscal reporting requirements to construction/renovation monitoring. The team feels that project management can be improved by engaging the USAID Engineering staff in an active role in the construction/renovation aspects of the Project. This will allow the Project Officer to devote more time and expertise to those activities of the Project for which trained.

5. Critical Review of UHD Background, Design and Issues

5.1 Critical Review of UHDP Background and Design

A significant portion of the implementation "difficulties" discussed in the preceding sections have their origins in, and can best be understood in terms of, the failings and defects of the UHDP project design process. Although the advantage of hindsight must be acknowledged from the outset, it does not negate our conclusion that the UHDP project design was much too complicated, overly ambitious, unrealistic, and inappropriate. It is not surprising, in retrospect that unnecessary (design-inspired) "implementation" problems have arisen and that the project is unlikely to achieve either its purpose or its goal. This section will attempt to provide a perspective on the project design process by examining some of the reasons underlying the above conclusion.

The UHDP was conceptualized in the early years (1976/7) of the present AID program in Egypt. The project's design represented a compromise between AID's desire to engage in the urban health sector (but with a primary health care-MCH emphasis), and the MOH's desire to construct and equip new tertiary facilities (e.g., hospitals). The "compromise" allowed each entity (AID and the MOH) to meet some of its objectives.

The MOH met its interests by obtaining funds to construct and equip eight new GUHC's secondary level polyclinic facilities offering a variety of services (not just MCH) and to construct and equip a new training, education and research unit (CSPM) to be attached to the Cairo University Pediatric Hospital.

In addition to the MCH components incorporated in the above, AID met its interests by funding the renovation and equipping of ten MCH centers (later increased to 33) and by funding data collection, training, education of health workers, and development of community participation, motivation and outreach activities.

An additional factor that influenced project design was AID's decision to opt for a "systems" approach. This entailed a multiple set of tasks that are, for the most part, of only secondary, if not peripheral interest to the MOH. The resultant outcome should have been expected. Construction, renovation and equipping of facilities have taken priority in terms of UHDP project office management time; health services related activities have placed an understandably poor second. Planned data collection and analysis have been accomplished in a professional and timely fashion by an Egyptian consultant group (ECTOR), but the intended institutionalization of these capabilities in the MOH has not occurred because MOH "counterparts" failed to materialize.

A final factor present during the project development stage completes the "background explanation." Under the twin compulsions to obligate large amounts of funds and to meet the Congressional mandate on "basic human needs," AID offered too much money. As a result, what originally was to have been a "small" \$5 million demonstration/pilot project quickly became an unwieldy \$25 million general institutional strengthening project that was somehow to be synchronized with the same project's demonstration/pilot efforts and with construction and renovation. What was to have been a largely health services focused project became primarily a construction/renovation/equipment project. This situation became even more pronounced as subsequent project amendments expanded geographical coverage and increased the construction/renovation/equipment focus.

It is with this type of background and development that the project entered its final design phase. Although the events described above tended to hamper meaningful institutional (system) change on the health services side from the outset, the prospects worsened with the failure of the design process to come to grips with what had occurred.

Rather than abandon the original demonstration/pilot health services focus, project designers chose instead to graft it on the new and larger health facilities construction/renovation/equipment model. Rather than give up anything, the project designers simply added new project components. The result was predictable. The project design became increasingly complicated, overly ambitious, unrealistic and even less appropriate.

The UHDP project design was far too complicated, particularly given AID's lack of experience in working in the health sector in Egypt. The project's many inter-related components depended upon a multitude of seemingly uncontrollable variables. The project's growing complexity increased the likelihood of major delays and decreased the chances of ultimately improving health services. Project coordination and synchronization simply became too difficult, if not impossible, as has become evident in the project's actual implementation.

The UHDP project design was also too ambitious. It actually consists of several projects: design and construction of GUHC's; design and construction of the CSPM; redesign and renovation of MCH's; design, testing, evaluation, demonstration, and institutionalization of the new CSPM operations, including an unprecedented MOH-University collaboration; collection and analysis of survey data and institutionalization of this capacity within the MOH. Finally, the institutionalization tasks envisioned or implicit in the project design were simply too much to accomplish in the five-year time frame of the original project design.

The UHDP project design was also unrealistic in many ways. As previously discussed, it tended to ignore real MOH priorities and the consequent probability of success fully implementing inter-related activities, many of which were not MOH priorities. The project design was unrealistic in ignoring the realities of the Zone and Governorate implementation function, given that MCH and primary care are but one of many responsibilities and certainly one of lower priority compared to tertiary curative responsibilities.

The project design was unrealistic in identifying problems and then ignoring them or assuming that they would be solved independent of any specific AID decision or action. For example, the project designers seem to have assumed that monetary incentives are important in making the MOH system function, but that motivation would be achieved in other ways, e.g., more pleasant surroundings, better training and supervision. In two subsequent amendments, poor design was only made worse by expanding geographical coverage and adding further project components. Finally, the project was seriously unrealistic in its implementation schedules for obtaining contractors under the host country contract and AID competitive procurement procedures, a fact that ultimately resulted in decycling of the implementation process from the outset.

The UHDP project design was also inappropriate. Given the project goal of improving health status, the project purpose ("to make the existing urban health delivery system more accessible and effective") offered less prospect for potential health status impact than alternative investments in areas such as water and sanitation systems. Nevertheless, even if the project purpose is accepted, inappropriate emphasis was given to the interventions selected. For example, construction/renovation/equipment are of lesser importance in affecting health status than human resource investments in management, supervision, training and incentive systems. The UHDP project design was inappropriate as an institutionalization vehicle in the way that organization and management of the project were conceived. The proper line of authority for implementation and institutionalization aspects of the project (i.e., the Undersecretary of Health for the Cairo Governorate) was by-passed. The UHDP project office was established as an adjunct to the regular MOH hierarchy in a planning capacity and was expected to pass the implementation tasks to the Zone and clinic directors (and their staffs) who owe their first allegiance to the Undersecretary and to the regular MOH hierarchy.

The mismatch of MOH and AID priorities, the systems analysis obsession of AID, and the compulsion to obligate large amounts of funds were all factors that from the outset rendered the Project relatively infeasible. The subsequent design decisions described above simply made a bad situation worse.

5.2 Project Issues

Some of the more important issues identified by the Team can be summarized as follows:

5.2.1 Health services have only minor effects on health status.

The UHDP takes an overall approach (improving health services) which is likely to produce less improvement in health status (the project's stated goal) than would be likely with other more specific approaches such as improvements in sanitation. The Project Paper (p. 2) notes that "Poor environmental sanitation, the lack of adequate water and sewage facilities, cultural practices and other considerations contribute to this overall low level of general health. However, a most significant reason is the lack of an effective and accessible urban health system with well-trained and highly motivated personnel providing outreach services and health care education in the target communities." Health Services are only one factor improving Health status; and reduction in IMR and other Health indicators will be difficult to measure as related to the project.

5.2.2 Inappropriate intervention emphasis to overcome service problems.

The UHDP's primary focus and its overwhelming emphasis (in terms of resource allocation decisions) is on construction and renovation, the results of which (i.e. new or improved physical facilities) have weak effects on the provision, quality, and acceptance of services.

Emphasis should be rather on incentive systems, training for competency, and tailoring of services and their provision to client's preferences, all of which have potentially strong effects. The project was initiated as a compromise with the GOE desire to finance construction of high visibility hospitals which have comparatively little effect on general health status. It emphasizes interventions (e.g., major construction and renovations) which appear unlikely to have major effects on either health or health services, and it leaves as assumptions such key factors as "Conditions of service can be improved to attract, retain and motivate qualified personnel to give better service".

5.2.3 Crucial service systems design elements skipped.

Protocols and systems for health service delivery have yet to be finalized in the project, but facility designs and training which logically depend on them have gone ahead without them.

5.2.4 Construction/renovation should not be managed by UHDP staff

The UHDP staff can't both manage construction and renovation and do the other parts of the project which are more likely to lead to improvements in health services and perhaps in health status.

5.2.5 Lack of Monetary Incentives in the regular MOH hierarchy.

Without adequate and replicable incentives linked to specified performance criteria, health services are unlikely to significantly improve.

5.2.6 Lack of competency based training.

Training within the project may not result in job competency because it is not competency based and is not evaluated to reinforce and ensure this outcome.

5.2.7 Probable non-replicability of pilot center demonstrations.

Demonstration efforts at the Tora Center may involve incentives and other factors which will not be replicable, even within the project.

5.2.8 Centralization of project administration.

The centralized administration of the project is dependent on one person. No adequate provision has been made for a deputy director. Unit directors have responsibilities without commensurate authority.

5.2.9 Location and temporary status of UHDP project office within MOH hierarchy.

The special project office which administers the project is a temporary section of the MOH with special powers and privileges. At the project's end in 1986, the office will cease to exist and its staff (obtained by secondment within the MOH, and paid high special incentives under a unique ministerial decree) will return to their primary MOH jobs. Without that office and the Executive Director's unique power base within the MOH, project activities (which otherwise would have advanced less than they have) are extremely unlikely to continue, especially with the present MOH management problems (see Section 5.1).

5.2.10 Lack of clarity and realism in project intent.

The UHDP (including its previous expansions) was intended to improve the accessibility and effectiveness of 32 MOH health facilities in Cairo and 11 in Alexandria. Those facilities theoretically serve target MCH populations of one and one half million in Cairo and one million in Alexandria. In view of the project's initial magnitude, and its expansions, its designation as a "demonstration" project, is a misnomer.

5.3 Likely Future Course of Project

At present, it appears that by the end of the project in 1986 the construction and renovation of MHC's and GUHC's, and probably of the CSPM, will be completed, if the corresponding recommendations in this report are followed. One of the GUHCs, at Tora (added to the project as the pilot center because it required little renovation), is expected to provide services as a pilot center by November of 1982.

It seems highly unlikely (on the basis of project implementation experience and the bad fit between project interventions and the key provider and user factors noted by the Urban Health Sector Assessment) that by 1986 the remaining centers will be providing significantly more or significantly improved services to the target population, or that the population's acceptance of and involvement in those services will have changed to any significant degree.

Given the project's complicated and ambitious design and the course of its implementation thus far, it appears unlikely that the project will make any major contribution to the goal of improving health status, even in the target populations. It also appears unlikely that it will improve the types, quantities, quality, and public acceptance of MCH services provided by the MOH, even in the new or renovated "demonstration" facilities which will have consumed most of the project's resources. Those elements which would have been likely to have significant effects on services and their acceptance have been allowed to lag far behind, while the project's staff devoted itself to construction and renovation efforts which the MOH was and remains ill-prepared to handle.

A review of implementation experience in each of the major areas of project interventions, other than construction and renovation, indicates inadequate development or application of a rational and systematic approach. A recent consultancy resulted in the project staff's becoming aware of and interested in one basic objective-focused method ("SIMS") for work planning, coordination and evaluation, but it is too early to assess the implementation of the method within the project.

The organization and administrative location of the project within the MOH seems unlikely to lead to any institutionalization of the capability to carry out further construction or renovation, much less the capability to gather and analyze data or use the findings to design and test or implement improved service programs, protocols, and systems. Neither does it seem likely that health service related capabilities being developed within the project staff will be transmitted to Zone and Governorate level counterparts, unless counterpart relations are effectively established on a regular working basis. A dichotomy exists between planning (special project staff) and implementation (regular MOH Governorate, Zone and clinic hierarchy) that threatens both present implementation of health service related activities and any institutionalization of the capabilities within the Governorate or Zone staff.

Interdependent project tasks are badly out of synchronization and some will be of questionable value by the time they are actually completed. As a striking case in point, protocols and systems for health services were still "under development" as of May 1982, according to a report by then-Project Officer Emily Leonard, although both the training programs and the new and renovated facilities should have been designed in terms of functional considerations which depend greatly on service systems, which in turn were to have been based in part on the Urban Health Sector Assessment which is only now about to become available.

Nevertheless, it should remain clear that the project can still largely succeed in achieving certain of its intended outputs. Approximately 72% of project funds are related to construction, renovation and equipment, all of which have high probability of being delivered by the project completion date if related evaluation recommendations are accepted. The balance of project outputs is much less likely to be delivered as originally intended.

6. UHDP in the Context of the 1982 Health Sector Assessment and Draft USAID Health Sector Strategy: Explanation of Dissonance

The 1982 Health Sector Assessment was carried out in the first half of 1982 by USAID consultants with the collaboration of the MOH. The Assessment concluded that major problems of the MOH render it much less effective than it would need to be in order to carry out its broad mandate in a way which would have major impacts on health. It also concluded that the MOH will be unable to adequately carry out preventive tasks which could have substantial impact on general health, and especially maternal and child health as long as it has its present heavy responsibility for curative services. This will be particularly true if those MOH curative services continue to be "free" for all patients. The assessment also noted that MOH services, in the context of structural problems related to GOE employment and civil service policies, are refractory to improvement.

The final report of the 1982 Health Sector Assessment, entitled Health Development in the Arab Republic of Egypt: A Sector in Transition, recommends that curative services be provided on a self-financing basis outside of the MOH, thereby relieving the MOH of this burden. With regard to existing AID supported MOH projects, including UHDP, the report (page xii) recommends that:

"USAID-supported projects now being implemented should continue in selected areas of high-focused concentration, but should not be expanded or extended unless they are restructured in the framework of overall health sector development".

A draft Health Sector Strategy developed by a USAID/Cairo expert team in August 1982 is now being considered by USAID/Cairo. The draft strategy suggests program contents for potential USAID assistance to Egypt's health sector in the next 5 years, in the context of the findings and recommendations of the 1982 Health Sector Assessment.

The special evaluation team agrees with the general findings and recommendations of the 1982 Health Sector Assessment, but bases its specific recommendations on several key additional factors. One is that the project's health facilities construction and renovation, which have high public visibility, are important to both the GOE and to U.S. support of the GOE; they therefore are not likely to be halted by USAID and could be successfully completed. A second factor is that the thus-far relatively neglected service improvement side of the UHDP, which involves a small proportion (20%) of USAID support of the project, offers the MOH a chance to show that it can improve its services. A third factor is the relatively high financial costs involved in stopping a project in mid-stream and terminating contracts early; and the relatively low opportunity costs of continuing a project once it has begun. The resulting waste from sunk costs and termination costs would be quite large.

35

Lastly, there is the relative momentum attained by the UHDP in mid stream which is difficult to recapture in any new project in its initial stages. Having worked through many of the implementation problems and basically understanding the ones ahead the UHDP would seem poised to make relatively rapid progress, at least on the construction, renovation and equipment side.

7. Feasible Approaches to Overcoming Implementation Obstacles of UHDP

Given the current status of the project, what could USAID and GOE/MOH do to increase the benefits of the project to the urban population of Egypt and indirectly to help promote political stability in Egypt? Some feasible approaches for each project area are reviewed.

The UHDP should be managed, by both the MOH and USAID, as several related but relatively independent subprojects. The Special Evaluation Team suggests the divisions shown in Figure 1 on page ___.

The construction and renovation elements of the UHDP are likely to be completed by the end of the project, in spite of delays, if the team's recommendations are followed. The main problems of concern now relate to the possibility that construction and renovation activities may result in the MOH losing leases on some of the rented facilities. If this is likely to occur, or if required permissions and evidence cannot be quickly provided, the problematic portions of the construction and renovation activities should be deleted from the project as unimplementable, as recommended by the USAID Engineer's report in Annex D.

The project directors, staff, and consultants should be relieved of concerns over the management of construction and renovation efforts. (The MOH has left commodity procurement almost entirely to a Westinghouse expatriate.) This can be accomplished by removing one of two antagonistic technical contractors/consultants, placing management of construction, renovation and procurement under the charge of the parties already under contract for such management work, and fully involving USAID engineers in the project's monitoring of those activities.

Relieved of the burdens of construction and renovation management, the UHDP staff could focus more time, energy, talent, and attention on other aspects of the project which are potentially much more important to improving services and health status.

The service improvement aspects of the UHDP must be greatly strengthened if any health benefits of the project are to accrue to the populations to be served. This will require reorganization of the UHDP central office and delegation of authority (and especially of influence over distribution of incentives) to project components and within them. The overall objective of these changes would be to improve, focus, coordinate, and manage activities intended to improve health services and their support.

This will increase the UHDP's chances of contributing to improved health. Achievement of this objective could even have some chance of facilitating institutionalization and replication of health services improvements, if the GOE and MOH were to decide to invest in such efforts.

In the recent past, the MOH has allocated insufficient and decreasing funds to cover the operating expenses of facilities, including new ones. Operating funds must include adequate incentives for good or outstanding performance by providers and managers, within performance guidelines and delivery systems which still remain to be developed as some of the most essential parts of this project. In order to increase funds available for operating expenses (particularly incentives), "Economic Clinics" could be widely instituted within the project. This would improve the financial base of MOH services, and it would also make possible a performance-linked provider incentive program. Economic clinics would help the MOH attempt to address some of the basic constraints under which it operates (i.e., inadequate operating funds, forced employment at relatively low pay of large numbers of physicians, and little effective control of "incentives").

In attempting to improve the quality and public acceptance of MCH services provided by the MOH, options not included in the original project design should be considered. One example might be rotation of staff from the proposed CSPM and from higher-prestige non-MOH facilities through MOH facilities. Full use should be made of the findings of the Urban Health Sector Assessment in the innovative redesign and provision of services to promote their acceptance and use by the target groups. If a "pyramidal" system of referral and treatment is to be established, for example, (as envisioned in the Project Paper) full attention should be given to the Assessment's findings regarding patient flows between the various systems, including the use of hospital outpatient facilities for "primary care". It may be necessary to promote better services at the hospital outpatient departments which many patients prefer, rather than hoping rather futilely to lure them away to MOH outpatient facilities.

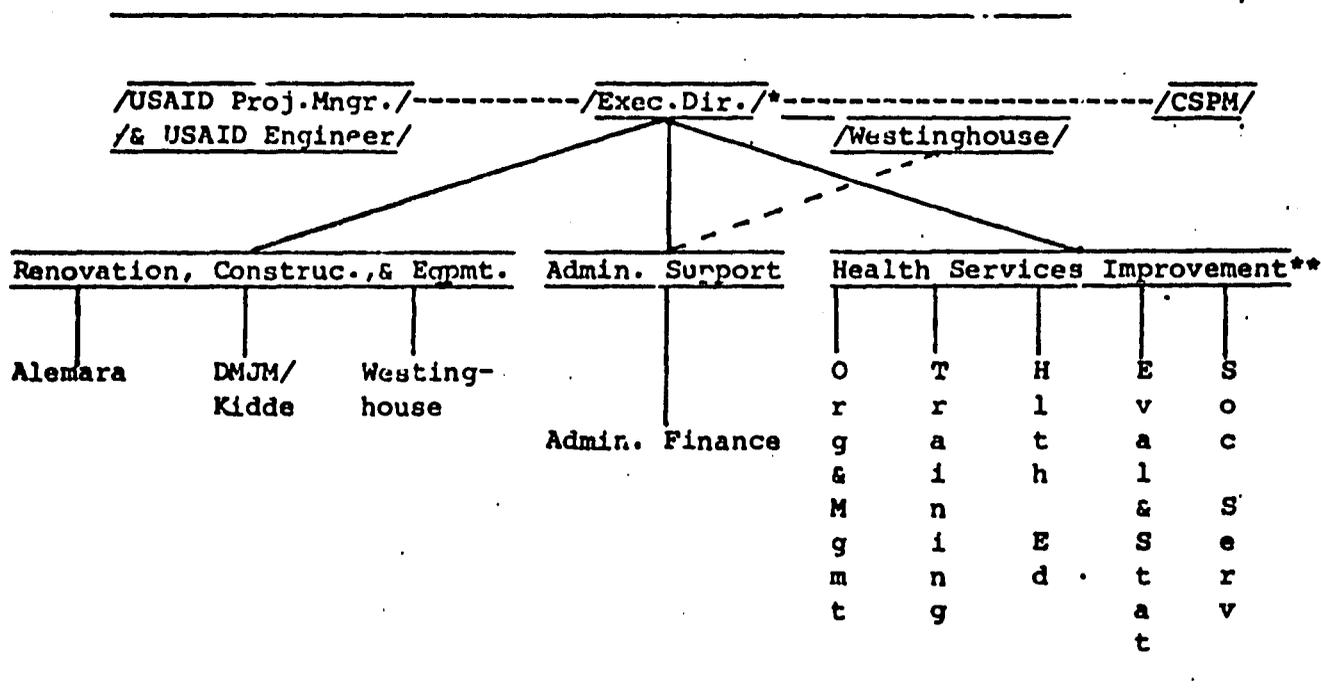
The disparities between MOH and USAID objectives for the UHDP might best be summarized as the distinction between MOH's interests in construction, renovation and equipment, and USAID's interests in service improvement. Service improvements might be advanced more effectively if acquisition of things the MOH wants were made contingent in future project agreements upon changes likely to lead to improvement of health services or health status. (An example would be to make some MOH-desired construction contingent upon prior development and application of a plan to link payment of provider incentives to personnel performance against present standards. The UHDP Executive Director told the evaluation team that the MOH soon expects to be able to give substantial incentives as part of a government-wide program.)

Detailed recommendations for the implementation of these approaches to increasing the effectiveness of the UHDP follow in Section 8 of this report. An Action Timetable and Responsibilities Chart is given as Annex F.

8. Recommendations

8.1 Project Organization and Management

Reorganize the UHDP Cairo central office (See suggested structure below) to facilitate the staff's achievement of UHDP objectives. The reorganization should specifically focus on the primary objective of improving health services provided by the project's urban health facilities. Management responsibilities for construction, renovation and equipping of facilities should be carried out by DMJM/Kidde, Alemara, and Westinghouse, respectively. Monitoring responsibilities should be conducted by a USAID engineer and a person to be assigned to be a proposed new position that should be created within the project office (both as recommended below). The executive project director should rely on this system for day-to-day management and monitoring and should limit personal involvement to executive decisions involving policy. The reorganization should rearrange present personnel and units to assure better focus and coordination within the project office for improving health services. Unit director authority should be commensurate with responsibilities (and to be effective must include greater influence over decisions related to incentive payments to staff under their supervision).



* MOH Zone Directors, who are Assistant Executive Directors of UHDP (See next recommendation), are not shown in this diagram, which addresses internal office reorganization.

** Within the key organizational change establishing three groups of UHDP central units (Renovation, Construction, and Equipment; Health Services Improvement; and Administrative Support), a revised plan for assignment of units to those groups and of functions to those units should be developed and included in the revised UHDP implementation plan. The unit assignments shown here are given only as examples

38

More effectively involve the regular MOH hierarchy in the implementation of changes and improvements under the project (e.g., the Governorate Undersecretary of Health, the zone directors, other zone officials, and health facility directors). This will require, among other things, incentives for their performance now in implementing those changes and later, beyond 1986, in maintaining and adjusting them over time. Appropriate counterparts from the governorate health staff and from each zone should be assigned to the heads of each unit of the UHDP. Implementation of health service improvement aspects of the project should be done through the MOH structure, with UHDP central staff members acting as program planners, technical support staff, and consultants for the governorate and zone staff of the MOH. (As an example, the zone directors should be active in directing service improvement implementation in their zones, and the other employees in each zone who are paid incentives for full time UHDP implementation work should in fact be working full time on that implementation under the project's increased emphasis on improving services.)

The Project should develop and use basic project planning, tracking, and management tools (flow charts of critical events and their timing; periodic formal reviews of project status and of individual staff and work group performance; etc.). This should be done with assistance from Westinghouse, and might be facilitated by the services of an expatriate planner for 3 to 6 months and the services within the project of an Egyptian who could perform some of the functions performed by Eng. Gazebeiah under ECTOR's MOH contract.

There should be a monthly joint meeting of Alexandria and Cairo UHDP (alternating between Cairo and Alexandria) for exchange of program information and experience (e.g., in training and programming) and for joint coordination of procurement, etc.

ECTOR should analyze, interpret, and present the results of the Urban Health Sector Assessment in such ways as to provide key decision makers with information which they can and will use in making major policy and operational decisions in and regarding the health sector. ECTOR should continue those activities, either under an extended UHDP contract or as UHDP special consultants.

The project should make available to the Minister of Health and to other key health sector decision makers ECTOR capabilities for strategy formulation and planning in the health sector, using existing UHDP funds to finance (as "innovative activities") ECTOR activities in these areas and in focused health services research to support them.

The availability of innovative funds (total of \$2.5 million) should not be "advertised", but rather the funds should be used to support (as opportunities arise) activities which the GOE and USAID consider to support the purpose of the UHDP

The Center for Preventive and Social Medicine (CSPM) portion of this special evaluation, postponed until January of 1983, should focus on what progress has taken place in terms of the stated objectives of the CSPM, and not only on construction planning. Institutionalized MOH - Cairo University Faculty of Medicine relationships, including ongoing staff interchanges between the two institutions, will be key to achieving these non-construction objectives, and plans for such relationships should be carefully examined. The January 1983 evaluation should be carried out over a period of approximately three weeks by a two-person team (Drs. Eugene Boostrom and Roy Smith, if available). It would be very beneficial to have the participation of Dr. Julius Richmond during part of the time, probably beginning near the end of the second week. Special inputs to the evaluation should be sought from Dr. Mahmoud Gabr of Cairo University Faculty of Medicine, from the Dean of the Suez Canal University Faculty of Medicine, Dr. Zohair Nooman, and from the MOH official who would assure later continuation of MOH participation in guiding and operating the CSPM.

8.2 Cairo MOH Activities and Inputs

8.2.1 Cairo MOH Construction, Renovation, and Equipment

Abolish the Senior Engineering Consultant position (contract expires December 1982) and those of his two assistants. This should all be accomplished within by December 1, 1982.

USAID technical monitoring of construction and renovation aspects of the project should be shifted from HRDC to IDPS. This will require 3 to 5 full work days per month, and essentially full time work during bidding and certain other critical periods, of a U.S. engineer with experience in monitoring and managing construction and renovation of public facilities in developing countries. Occasional assistance (one to four work days per month) will be required of a USAID Egyptian engineer in support of the USAID American engineer.

Create a new (intermediate level) position in the project to give the executive director necessary non-technical administrative support and monitoring for construction and renovation aspects of the project. See suggested scope of work for this position in the USAID Engineer's report done as part of this evaluation (Annex D).

Extend Alemara's A&E contract beyond the present October 1982 expiration date until completion of renovations, adjusting the scope of work and payment schedule in view of delays and of changes in renovation contract scopes of work.

Immediately stop external additions presently planned in the renovations of at least five of the eleven privately owned facilities, until USAID-Cairo (Legal Office) is satisfied by GOE certification or other means that:

40

- a) there are not unacceptably high risks that the GOE will lose use and control of those facilities and
- b) the GOE has legal authorization to proceed with the scheduled/planned renovation work.

Immediately review legal right of MOH to conduct interior renovations in the eleven privately owned facilities, and assess risk (cost/benefit) of continuing renovations should legal right be clouded. The GOE should immediately provide to USAID the legal documents necessary for these reviews.

Assure that all equipment and furniture necessary for the improvement and acceptance of services at the renovated MOH facilities will be ready for installation and operation when renovations are completed, to avoid further delays in opening and possible lessened impact on services and on their effectiveness and public acceptance.

The MOH must officially assign counterparts to the Westinghouse Equipment Specialist so that planning can proceed for providing equipment for the GUHCs and the CSPM and so that necessary preparations for supply and maintenance can be made.

8.2.2 Cairo MOH Service Improvement, Training, & T.A.

"Economic Clinics" charging reasonable fees should be widely instituted and evaluated under the UHDP, with the clinics' income being used (in accordance with MOH regulations) for purposes including performance-linked monetary incentives to providers (and to zone personnel if possible). This is necessary because it is widely agreed at all levels that continued lack of effective monetary incentives would probably mean continued substandard staff attendance and performance in the upgraded facilities. Experience in Egypt, as elsewhere, indicates that to be effective incentives must be tied to monitored performance.

The project should make full and effective use of the technical assistance available to it under the Westinghouse contract, with a clear concentration of both project and technical assistance efforts on improving health services delivered at or through MOH urban health facilities.

(NOTE: The next three recommendations are intended to improve support by the central UHDP staff of widespread implementation of basic health services improvements throughout the 32 Cairo facilities involved in the project. It may be necessary, in addition to the Tora pilot effort, to phase certain aspects of those improvements by selecting one or more facilities in each of the four remaining zones for initial implementation

of those aspects. Other improvements, however, can and should be immediately implemented in all of the UHDP facilities, using regular MOH zone and facility staff with backing from the UHDP.)

Immediately implement in the project's health facilities (in coordination and conjunction with related efforts of other groups) service delivery improvements of demonstrated effectiveness (e.g., strengthened ORT, home visiting, and community outreach).

Extend training and service improvement activities to the North and East Zones of Cairo, rather than doing only renovation and construction in those zones.

Immediately develop and implement a simple plan and schedule (based on present staff capabilities) for activities to be carried out by health facility staffs while facilities are being renovated. The plan might emphasize outreach and community orientation activities and introduce priority activities to be carried out later in and through the renovated facilities. Implement this plan in those facilities where estimated renovation completion dates are later than January 15, 1983.

Plan and prepare immediately to implement, monitor, revise, and evaluate activities at the Tora GUHC (and to use results immediately to improve activities at other centers), so that effective pilot operations at the center can begin as soon as the renovations at the Tora center have been completed.

Develop a plan to train and utilize selected governorate, zone, and facility staff members in the implementation of health services improvements in all facilities involved in the UHDP. This will require incentives linked to good performance in those areas on the part of both UHDP and regular MOH staff. It will also require organization of the UHDP central staff specifically to support those efforts, probably through formation of teams which will assist zone and facility staff to initiate improved services in each facility as it opens after renovation or construction.

Project planning staff should exercise flexibility in determining which services and activities will be given priority in service improvements, in order to maximize health benefits of the services (e.g., in determining implementation priorities and schedules during and after renovations, and in adding or replacing activities in the light of added knowledge and experience later in the project).

Training must produce demonstrated competence of workers for tasks which their jobs require in implementing service improvements. The project must focus, organize, time, and validate training activities to accomplish this.

Out-of-country training should be more focussed on the needs of the project and should not be taken as a "given". Determination of future intended use of the trainee and appropriateness of the trainee's new or currently assigned position, in light of new training, should be mutually agreed upon prior to initiation of training request.

This will require stronger justification from the UHDP staff and a greater involvement of Westinghouse advisors in developing future training plans. Consideration must be given to a more useful distribution of scholarships, with fewer tours and visits to previously-visited sites and by those who have already benefited from project-sponsored trips. Specifically, many of the trips should be used as incentives and learning experiences for zone personnel and for MOH officials who will be able to use their knowledge to improve and operate MOH health services in future years.

The CSPM's organization and activities should be directed clearly toward accomplishment of the stated objectives of the CSPM and those of the UHDP.

8.3 Alexandria MOH Activities and Inputs

MOH activities under the project in Alexandria should:

Be carried out under local direction and with local control of MOH incentive funds assigned to that part of the project.

Include (additional?) service improvement efforts, without awaiting Cairo UHDP progress. The director and staff of the Alexandria UHDP should develop a proposal to do this, for potential additional funding under the "innovative" activities project funds.

Continue to build on the ongoing training efforts of the Alexandria governorate MOH and to introduce new methods of training.

Have support from the UHDP Cairo staff, as needed and on request.

Have the full time services of fully qualified personnel for the four positions and support personnel which the MOH is committed to supply under the grant agreement. MOH should recertify this before AID releases funds for renovation contracts.

Develop and use basic project planning, tracking, and management tools (flow charts of critical events and their timing; periodic formal reviews of project status and of individual staff and work group performance; etc.). This could be done by Robert Earey under his present personal services contract, with assistance from the expatriate planner suggested to work for 3

to 6 months on the same tasks in Cairo and possibly with the services within the Alexandria project of an Egyptian who could perform some of the functions performed by Gazebeiah under ECTOR's MOH contract.

8.3.1 Alexandria MOH Renovation and Equipment of 11 MCH Centers

Health facility renovations in Alexandria should take full advantage of the project's experiences in renovations in Cairo, in order to avoid, as possible, the legal, contractual, and procedural problems encountered and expected in Cairo, specifically:

Do not hire a consultant to supervise the A&E contractor.

Do create a new (intermediate level) position to give the Alexandria UHDP director necessary non-technical administrative support and monitoring for construction and renovation aspects of the project.

Do involve MCH center personnel in functional planning for renovations.

Do use USAID engineers to monitor progress and provide other engineering assistance for this component.

Do have legal permissions lined up from private owners before renovations begin.

Do not move clinic staff into temporary facilities until renovations are actually ready to begin (i.e., permissions obtained; contractors mobilized; etc.)

Do closely coordinate equipment needs with UHDP Cairo staff.

Do prepare justifications, schedules, utilization and maintenance plans, and administrative control procedures for vehicles required for the MCH clinics.

8.3.2 Alexandria MOH Service Improvement, Training, & T.A.

Keep the size of the Alexandria UHDP staff small. Emphasize use of present MOH officials and staff and of their knowledge and experience, within their present regular MOH positions, in developing and implementing the project's training and service improvement activities.

Project planning staff should exercise flexibility in determining which services and activities will be given priority in service improvements, in order to maximize health benefits of the services (e.g., in determining implementation priorities and schedules during and after renovations, and in adding or replacing activities in the light of added knowledge and experience later in the project)

Develop a plan and a definite schedule for activities to be carried out by health facility staffs while the facilities are being renovated (perhaps emphasizing outreach and community orientation activities, and introducing the priority activities to be carried out later in and through the renovated facilities).

8.4 Alexandria HIO Inputs and Activities (Computer and Information System Equipment, and Related Training and Technical Assistance)

Plans for the Alexandria HIO portion of the UHDP should include adequate provision for:

Ongoing analysis by HIO of their information needs and of HIO capacity to interpret and use the information system's outputs, with feedback into the system to add, delete, or modify content, procedures, and outputs.

Incentives adequate to permit development (or recruitment) and retention of personnel with adequate computer and information systems skills.

8.5 USAID Management and Monitoring/Evaluation of UHDP

USAID should request that a pair of monthly status/progress reports (2 to 3 pages each) be submitted by UHDP Cairo and UHDP Alexandria, in order to assist the USAID Project Officer in monitoring the project and to constantly call implementation progress in all areas to the attention of the projects' directors. One of the pairs of reports would cover construction, renovation, and equipment, and the other would cover health services improvements. Each would cover:

- Status reports of key items (possibly using a prepared form) against planned progress
- Items completed (including problems resolved)
- New problems requiring action.

ANNEX A

Scope of Work for the
Special Evaluation of the UHDP,
August/September 1982

A. Introduction

The Urban Health Delivery Systems Project was last evaluated in May 1982 by the A.R.E. Project and Westinghouse Health Systems Contractor staff. All phases of this multifaceted project were reviewed including interventions being planned to improve health services; technical assistance provided by contractors; incountry training; cooperation between the MOH and the University of Cairo; construction and work; and commodity procurement. The evaluators made recommendations to the Project Executive Director on the future direction of the Project.

This special USAID evaluation will use the May 1982, 24 month evaluation as a starting point in an effort to analyze those recommendations, build upon them and to provide the A.R.E. and USAID with further suggestions for the implementation of the Project over the next 24 months.

B. Objective

The overall objective of the evaluation team (Dr. Eugene Boostrom-AID/W, Mr. Robert Rucker-USAID/Program, with Mr. John Wiles-USAID/Health-as the coordinator) will be to review the Project in terms of its impact on achieving its stated purpose of "to make the existing urban health care system more accessible and effective"; and to determine whether or not resources available to the Project are being used to the maximum benefit of the Project. The team will also consider changes in the Project design and in the implementation schedule contained in the Project Paper which would clearly improve implementation of the Project through its completion date (November 1986).

C. Specific Tasks

In order to arrive at the evaluation objective, the team will:

1. Review and become familiar with the contents of the 24 month evaluation report, the Project Paper, the Project Work Plan and other documents as appropriate.

2. Develop a better understanding of the actual nature and workings of the Project by attending briefings conducted by the Egyptian Project Staff, contractors, USAID staff and others as suggested by the Executive Project Director and USAID, (e.g. MOH officials, members of the Project Executive Board, University representatives - note: evaluation of the Center for Social and Preventive Medicine (CSPM) component of the Project is being delayed until January 1983 at the request of the Project Executive Director).

3. Conduct indepth reviews of the various program components through individual interviews with all project staff and contractors.

4. Conduct a selected series of interviews with clinic personnel, users and others (e.g. Zone officials outside the MOH, private community groups) as appropriate to obtain a sense of the impact of the project on the target groups. This will be done with the assistance of an Egyptian Social Scientist, Dr. Nawal Nadim.

5. Review the status of construction and renovation work with the assistance of Mr. Robert Cook, USAID/Engineering.

D. Questions/Issues to be Considered

1. What is the status of the Project in relation to its purpose? Is this still the appropriate purpose that can be achieved by the end of the Project (November 1986)?

2. The original project design envisioned "developing within the MOH the capability to perform on a continuing basis, assessments of the health sector designed to provide the data and information required to plan, implement and evaluate delivery of health services which are more relevant to the needs of the consumers". ECTOR, through a contract with the MOH, has conducted fairly extensive assessments in some of the project areas. What use has been made of this data? Has any institutionalization of the planning process taken place in the MOH, and/or in the Project Office as a result of this work? What are the prospects for the future? Is the institutionalization of a function (i.e. Health Planning) outside the immediate project organization a reasonable objective for a project of this nature? Or, should it be a separate project? What can be done to strengthen the health planning capability of the Project Office and the Governorates/Zones by the Project? Is this the more appropriate role for the Project?

3. Is the existing organizational structure for implementing the Project now appropriate in view of the fact that activities have expanded to a second urban area, and might conceivably be expanded to other urban areas in the immediate future? Should further decentralization be considered for Cairo? Should resources other than the MOH's be used to support activities in Alexandria, as for example the High Institute of Public Health?

4. What is the status of construction/renovation activities? Are changes needed in contracts? What are the current estimates for completion of all work by type? Are planned project funds for this work sufficient?

5. Construction/renovation activities have consumed a large portion of the Executive Project Director's and Project Officer's time. Should the present system of having technical staff oversee construction/renovation continue? Or, should oversight be moved to other organizational units (e.g. for USAID to the Engineering Office; and for the Project Office, to an office in the GOE which normally takes care of this type of work) thus allowing the Project Staff to devote more of their time to the technical aspects of the Project?

6. What is the status of interventions (e.g. ORT, Drug Packaging) being developed by the Project Staff? Are they replicable to other areas, and specifically to Alexandria? Should other interventions be considered along with the ones already developed? What mechanism should be used to insure a smooth transfer of knowledge gained from Cairo to other urban areas; and from other areas to Cairo?

7. How many and what types of people have been trained in-country under the Project? Have organizational changes been made which give these people the opportunity to use the training received (e.g. are supervisors also trained in the new concepts; are job descriptions being revised to take in account new duties, etc.)? What should the future emphasis be?

8. How many and what categories of staff have received training abroad? What use is being made of this training? Are the Project Paper projections for training still valid (i.e., 2 per year for long-term academic; 4 per year, short-term academic; and 6 per year observational)? If not, what would be a more appropriate mix?

9. Originally, it was planned that the Westinghouse Contract Technical staff would work only with the Cairo staff. Is this still appropriate? Is TA a necessity for other urban areas? Should the WHS contract be the vehicle for providing this TA if needed in other areas? What types of consultants are needed in the future?

10. What is the attitude of clinic staff and the users of the services towards the Project? Has there been any impact on their use of facilities as a result of improved services (it may be too early to judge this)? Do users feel that the project can be of benefit to them in the future?

11. The Center for Social and Preventive Medicine is to provide a link between the government (MOH) and the university setting. What is the likelihood of this happening? Should links between the CSPM and other urban areas be fostered?

12. Are the Health Insurance Organization (HIO) activities being funded under the Project still appropriate (i.e. computer purchase and TA to use it)? Should TA be broadened? Are there other needs?

13. Funds were made available in Amendment #2 of the Project Paper for "innovative activities". The HIO component is one such activity. What should the priorities be for other possible activities? What type of activities should not be funded? In view of the already complicated nature of the project (in terms of implementation), should innovative activities be eliminated altogether (except for HIO)?

14. What is the status of commodity procurement for the General Urban Health Clinics and the CSPM? Are additional vehicles needed?

15. What is the status of Family Planning activities in the project areas? Are redirections needed?

16. Other questions and issues that may arise as the evaluation proceeds may also be pursued by the team.

ANNEX B

Principal Reference Materials

Used by the Special Evaluation Team.

1. Project Paper, UHDSP, October 14, 1978
2. Project Paper Amendment No. 1, UHDSP, August 30, 1979
3. Project Paper Amendment No. 2, UHDSP, June 25, 1981
4. UHDSP Project; 24 Month Review and Recommendations for Future Implementation, May 25, 1982.
5. Urban Health Project Summary, E. Leonard, April 14, 1982
6. Notes on the 24 Month Review and Recommendations, E. Boostrom, June 1982
7. Final Report of Consultation (CSPM), Roy Smith, July 1982
8. Evaluation Study on Services and Performance in MCH's and GUHC's, September 7, 1982
9. Implementation Plan, UHDSP September 1981
10. Plan of Action, CSPM, July 1981

ANNEX C

Key Persons Contacted by the
Special Evaluation Team,
August/September, 1982

1. UHDSP Central Office (Cairo)

Dr. Nabahat Fouad, Executive Project Director
Dr. Farouk Gaffar, Director Organization and Management Unit
Dr. Insaf Hanna, Director Human Resources Unit
Dr. Ibrahim Missak, Director IEC Unit
Mrs. Ikbal Hanna, Social Work/Outreach Section
Dr. Fawzy Gadalla, Chief Technical Consultant
Dr. Ahmed Talaat, Chief Engineering Consultant
Dr. Wafik Hassouna, Principal Investigator FCTOR

2. MOH

Dr. Osman el-Zimaity, Undersecretary of State for Health, Cairo
Dr. Said Tawfik, Undersecretary of State for Health, Alexandria
Dr. Mahmoud El Mattery, General Director for Health, Old Cairo Zone
Dr. Mohamed Fathi Sheba, General Director for Health, South Zone
Dr. Weded Attalla Boulos, General Director for Health, North Zone
Dr. Mahmoud Abd el-Salarn Ali, General Director for Health, Zeiton Zone
Dr. Said el Sharkawy, General Director for Health, Shobra Zone
Dr. Gamal El Din Nasr Mansour, General Director for Health, Helwan Zone
Dr. Mohamed Shawki Tomoum, General Director for Health, Abdin Zone
Dr. Mahmoud Khairy Said, General Director for Health, West Zone
Dr. Doreya Lelin, General Director for Health, East Zone

3. CS&I

Dr. Mamdouh Gabr, Director, Pediatrics Department
Dr. Hussein Kamel, Professor of Pediatrics
Dr. Ahmed Safwat Shukry, Pediatrics Department
Dr. Ahmed Koth, Professor of Pediatrics
Dr. Ahmed Hanafy, General Director Cairo University Hospital
Dr. Lotfy El Sayyad, General Director, MCH, MOH

4. Alexandria UHDP

Dr. Nawal Kassem, Project Director
Dr. Amira Kamel, Training
Dr. Hassan Rashed, Interventions

5. HIO

Dr. Mohamed Shehata, Director North-Western Branch, Alexandria

6. Contractors

Dr. Steve Simon, Chief of Party, Westinghouse Health Systems, (WHS)

Mr. Forest Neal, Equipment Specialist, WHS

Mr. Elton Kern, A & E DMJM/KIDDE

Mr Robert Emery, Technical Advisor for Alexandria

Dr. I. Karim, A & E, Alemara

7. USAID

Owen Cylke, Acting Director (at the time)

William D. Oldham, MD, Director, Office of Health

John Blackton, Special Assistant to the Director

Emily Leonard, Program Economist, former Project Officer

Riad Imam, Engineer

ANNEX D

Special Evaluation of the MOH Urban Health Delivery Systems Project

USAID Engineer's Report on Facility Renovation and Construction

by
Mr. Robert Cook

1. Objective

I was asked by HRDC/H to review this project with the primary objective of evaluating construction and a secondary objective of developing suggestions for managing construction elements of this project and of possible future HRDC projects.

2. MCH Center Renovation Activities

2.1 MCH Center Renovation Activities: Overview

Discussion of Cairo Area Projects: Of the 22 MCH clinics being remodeled, none are ready for occupancy at this time, although renovation work at 4 clinics (Masr El Kadima, Helwan Masakin, Shoubra 2nd and El Maadi) should be complete by October 1st. The scope of work on each clinic varies from internal renovation with minimum alteration to complete reconstruction. The quality of work observed was good to very good, especially when compared to work observed on other AID-funded projects.

2.1.1 Project Organization (Engineering)

The A & E Consultant to the MOH for the MCH center renovations is a firm called Alemara, which reports directly to the UHDP Executive Director, Dr Nabahat Fouad. Alemara's chief representative is Dr. Eng. Ibrahim Karim. Dr. Nabahat has also obtained the services of an additional private consultant engineering advisor, Dr. Eng. Ahmed Talaat. Engineer Talaat's role is that of advisor to Dr Nabahat, and he has no official jurisdictional role in the project.

The project's renovation work is divided into five zones, and all work in a zone is combined as a unit under one contract. The A & E consultant (Alemara) has organized his field surveillance by zones.

2.1.2 Basis for Comments on Findings

In attempting to define problem areas and their sources and implications, I have encountered a welter of claims, counter claims, conflicting statements and biases. The comments presented herein are to the best of my knowledge accurate and in all cases represent my observations or a consensus of persons interviewed.

2.2 MCH Clinic Design Delays

2.2.1 Delay caused by loss of original drawings

The project schedule was thrown into disarray at the outset. The MOH was unable to find the original drawings of the facilities, which required Alemara to measure and redraw the "as-built" drawings for each building. This is the first design delay in the project and is an MOH responsibility. These drawings had been available when ECTOR made an initial study, but disappeared in the intervening period.

2.2.2 Delays Caused by Increase in Scope of Work

Background:

Under the ECTOR program (in 1978), a study was made by Yousef Shafik regarding the upgrading of the MCH Clinics. The MCH Clinic remodeling project which is now underway, and is the major subject of this report, was spawned from that report. There are some differences in the assessment of the amount of rehabilitation needed as described in that report, and as finally performed. Ten of the 22 Clinics were included in the ECTOR report and the present project scope was written with that report as a basis. In my discussions with Dr. Nabahat, she was unaware of the existence of this report as a basis for the scope of work. The development of the total scope of work which included all 22 MCH Clinics was not in depth enough to accurately assess the work needed, partially due to the superficiality of the Shafik report.

The specifications (IFB) in Annex II of the study lists the sites, with two general categories of scopes of work. These categories are: "Category I - Require repair in sanitation, flooring, painting, electrical installations, and other non-structural improvements. Category II - Require major repairs in the building, which could include some reconstruction."

Both of these categories indicate a much more modest amount of work than that ultimately contracted for (i.e., than that found to be necessary by Alemara and the MOH). My observation was that all sites required at least "Category II" level work and that most went well beyond that; as an example, Helwan Awal is effectively a new building. This increased scope required more design effort and more project funds. This is the second design delay in the project and it is the most serious as it produced the third delay. This delay can be attributed to the lack of in-depth study of the original scope of work.

2.2.3 Delay Caused by Necessity to Obtain Increased Funding From AID/W:

The bid opening was delayed extensively while awaiting increased funding from AID/W. This is the 3rd design delay and is a direct

result of the failure to properly evaluate the scope of work.

2.2.4 Delay caused by rebidding

The IFB had to be issued a second time when all the bids received exceeded the Engineer's estimate, and a third bid was required as competition was lacking on bids for the buildings in Zone 2. This rebidding process is the 4th design delay and is not attributable to any particular agency or person. However, some delay was caused because Alemara had misinterpreted USAID approval of designs as approval of IFB and prematurely issued the IFB.

At this point MOH personnel stated: (1) proper permission to erect temporary clinics (referred to as "shacks") had been obtained, (2) permission to make addition to rented property had been obtained from the appropriate officials and landlords, (3) the local MOH clinic personnel were aware that they would have to vacate the MCH center buildings and move into the temporary facilities. These three issues are stated here as they lead to virtually all of the delays in the construction period. Alemara and Engineer Talaat both state that those issues had been discussed at a general meeting at which MOH zone directors stated that they had the proper permissions. This is verified by USAID personnel who attended that meeting.

2.2.4 Summary of Design Stage Delays:

- 1) Loss of original drawings (which required Alemara to remeasure and redraw the buildings) (MOH responsibility).
- 2) Increase in scope of work (requiring more design time and more project funds) (Initial A&E Consultant - ECTOR Study).
- 3) Necessity of getting additional funding (and approval of that funding from AID/W) (See 3 above).
- 4) Rebidding (See 3 above).
- 5) Failure to get USAID approval prior to issuing IFB (Alemara).

2.4 Comment on the Design Delays in MCH Center Renovations

Remodeling/renovation projects are notoriously difficult to assess, and they often involve increases in scope. Nevertheless, the original scope of work should have been much more accurately defined than it was. All of the above delays can be considered somewhat

normal, although more extensive than usual (and certainly regrettable), except for the loss of the original drawings which is most unusual. Considering the above, the delays in the design/bid phase of these projects are understandable. The redrawing of the "as-builts" was accomplished more promptly than would normally be expected.

3 MCH Clinic Construction

3.1 MCH Clinic Construction: Overview

As the contracts were awarded and the contractors attempted to start work, major problems began to emerge and the project began to unravel.

3.1.1 Construction delays caused by the vicissitudes of working on rented properties

Excessive delays have been experienced because of a failure on the part of MOH to obtain adequate permission to perform work on rented properties. This is the first major construction delay and is one of the most serious as it has caused several of the other delays. It is clearly the responsibility of MOH to give the contractors clear access to the work they have contracted to perform. This problem will certainly be the basis of claims and could result in strenuous efforts by the landlords to repossess their properties. The background of this problem is explained as follows: Several of the clinics (11 of 22) are rented from private landlords, which introduces special problems. Because the rents are exceedingly low and the tenant (MOH) is virtually impossible to evict, the property owner has little incentive to cooperate. There are legal limits, under Egyptian law, regarding the amount and type of work that can be performed on rented property without the owner's permission.

It is not clear whether the MOH failed to get permission from the property owners, or whether the owners gave verbal permission which they later revoked, or denied. It is certain that the permission is now disputed and has been a source of aggravation, delay and additional cost to the contractor. The owners object to the remodeling, as well as the additions, and have harassed the contractors by visiting the sites regularly and objecting to every thing. This delay is the major cause of the redesign, and the inability of MOH to give the contractors unrestricted access to their projects. (See paragraphs 3.1.3 and 3.1.5). It has also produced temporary clinic location delays, (see Paragraph 3.1.2) and it raises the issue of landlords reclaiming this property as discussed in Paragraph 3.2.1.

3.1.2. Delays caused by disputed temporary clinic locations.

Temporary clinics are to be constructed where necessary to allow continued MCH Clinic operation. These are either on the same property as the clinics or on public land in the vicinity. These shacks have been erected, torn down, and reerected at another locations several times, in several instances.

Apparently the MOH simply made the assumption that they could erect temporary clinics on their rented property and/or they had verbal permission which was later revoked. Where clinics were constructed on public land, it seems that proper permission was obtained from the local authorities. These local authorities have difficulty maintaining a consistent position. In several cases, it appears they have subsequently revoked the permission capriciously when an objection arose. This is the second major construction delay and is clearly the fault of the government. MOH should have been aware of the problem of siting these temporary shacks on private property, however they have no apparent involvement in the dispute regarding public placement. The net result has been a variety of bizarre occurrences, including: landlords' re-seizing portions of their property and building apartment houses or fences; arrest of contractor crews for trespassing; physical assaults on contractor personnel; destruction of construction already in place; theft of stored material; other harassment.

Zone 3 has been especially a problem as there is a sort of local range war perpetually in progress in that area between various factions. (Note: Residents may have objected to the use of public land for temporary clinic facilities because they are skeptical of the government's intention to return them to other public use.) Dr. Nabahat blames this problem on one official who has since been transferred. Nevertheless, this is an on-going problem with the latest incident occurring as recently as August 23rd of this year. In at least one instance a temporary building has been erected three times and dismantled. In the zone near Ramses Square (Zone 1) the contractor complains that he has been prohibited from starting in 3 of 5 buildings for this reason. Although it is normally desirable to get local citizen involvement in this type of project, the manner and type of involvement in these instances have been counter-productive.

3.1.3 Delays caused by redesign

In an attempt to avoid these complications and to prove that the additions are of a temporary nature, a decision was made to redesign 5 of the additions, utilizing aluminum. (The aluminum additions are discussed separately in this report.) During construction the clinic building at El Musky was found to be in an advanced state of deterioration and in need extensive structural repairs. Since the contract for this zone contained no quantities for additions this work must be renegotiated. Also the contractor has written a letter

denying any responsibility for the repairs due to the state of the building. El Qalaa required redesign of the additions because of owner objection to its placement. Boulahia will require redesign when the structural problem is resolved. This is the third construction delay and is ongoing.

3.1.4 Delays Caused by Resistance of Local Clinic Personnel

MCH center personnel have been reluctant to vacate premises or to move into smaller temporary facilities. The contractors and Alemara state that significant delays were encountered in getting the clinic personnel to move into temporary facilities, and in some cases the personnel refused to let the contractors begin work initially. The size and type of construction of the shacks was one problem mentioned. In other instances, the operating personnel seemed to be reluctant to interrupt their services. Generally these problems were resolved by negotiation between the contractors and the clinic personnel; often a tradeoff resulted with some favor given to the clinic personnel, such as allowing them to remain in one or two buildings while others were being renovated and so on. This is the fourth construction delay and is the responsibility of MOH. Dr Nabahat denied that this problem occurred in more than 10% of the clinics, although the contractors and Alemara state that it occurred repeatedly.

3.1.5 Delays caused by slow Payment of Invoices:

The contractors state that they have been receiving payments 2 to 3 months after submission of vouchers. They have had to suspend work on occasion until invoices were paid. The contract calls for 20 days maximum between submission of invoice and payment. This is the fifth construction delay and should be resolved immediately as it is unfair and may result in claims. This delay may be an outgrowth of the dispute on documentation of invoices which is discussed later in this report. Alemara admits to being at fault for at least a portion of these delays, and has arbitrarily delayed payments recently in an attempt to get contractors to submit progress schedules.

3.1.6 Delays caused by Inability of MOH to give contractors unrestricted access to their zones.

To avoid dealing with a different contractor on each clinic, and to promote efficiencies a decision was made to let all the work in one MOH administrative zone as a unit. The contractors submitted their bids on that basis, and are now denied access to major portions of their projects. The contractors point to this as one reason they have been unable/unwilling to make better progress on the portions that are accessible to them. This is an issue in 4 of 5 zones and is the sixth construction delay. It is an outgrowth of the other problems.

3.1.7 Summary of Construction Delays:

1. Failure to get owners' firm written permission to remodel privately owned property. (MOH)
2. Failure to provide for undisputed areas for temporary clinic locations. (MOH)
3. Requirement to redesign additions to rented property using temporary type materials. (MOH)
4. Lateness of contractor payments. (Alemara)
5. Reluctance of doctors to vacate clinics or to occupy temporary shacks. (MOH)
6. Inability of MOH to provide unrestricted access to all clinics in a zone. (MOH and Local Government)

3.2 Comments on Construction Delays:

The progress on these renovations has been disappointing. However, taking into consideration all of the above problems, it is not surprising the project is well behind schedule.

Delays 1 and 2 are major delays which are as yet unresolved, and are clearly management problems which should be resolved by MOH staff or their consultants. They are not the responsibility of the A & E Consultant or construction contractor. Delays 3 and 4 are major delays which are as yet unresolved, and are aggravated by the lack of cooperation between Dr Talaat and Dr Karim. Delay 5 was a relatively minor delay which seems to be resolved. Delay 6 is a result of the other delays and the contracting mode. These delays and suggestions for resolving them are summarized in paragraph 3.4 thru 3.4.4

3.2.1 Progress in Zone 2

It should be noted that in Zone 2 the work is proceeding quite well and the quality of the work is very good. It is my understanding that the Zone Director and Alemara cooperated in solving problems in this zone. This zone did not have either the aluminum redesign problem or the "shack" problem, and the contractor has had relatively unrestricted access to his work. Dr. Nabahat attributes this success to the contractor, being in her words "a very good contractor". It seems that the owner of the privately owned clinic building (Halwan Awal) has been cooperative. This building was completely redesigned after contract award. There is no written agreement between the landowner and MOH regarding these constructions.

3.2.1 Latent Issues to be Considered

There are two large issues which have not been confronted to date. First the contractors certainly have more than adequate grounds for extensive claims, and in fact mentioned this subject peripherally in our discussions. Secondly there has been concern expressed that the owners have yet to be heard from. They may make a concerted effort to reclaim their property based on legal technicalities. There is ample evidence for this concern. At Ain Shams a portion of the site has been seized by the owner and subdivided. At Al Zatoon the owner has seized onehalf of the site and erected a 5 story apartment building on it. At Al Musky the owner has convinced the local authorities that the building is unsafe, however this matter is now being contended by MOH. At Al Assal the owner has erected a fence which effectively precludes additions to the building.

3.3 Conflicts between Alemara and Engineer Talaat

An atmosphere of conflict seems to have evolved centering on differences of opinion between Engr. Talaat and Engr. Karim. This devisiveness tends to be an underlying and recurrent theme in discussion with almost all personnel contacted. They appear to have been a significant factor in prolonging several of the delays.

3.4 Aluminum Additions

To obtain the functional relationships considered desirable by the MOH, the original design included additions to seven of the rented clinic buildings. As the MOH became more concerned about their legal rights, a decision was made to redesign the additions to 5 of these buildings using a more temporary material, in this case aluminum. These additions are designed to have reinforced concrete footings, a concrete slab floor, prefabricated aluminum walls and a prefabricated roof. Alemara has suggested that the landowners be notified of this intention and their approval given prior to proceeding. Dr. Nabahat does not want to get landowners' approval as she feels it may highlight the issue and create problems. She states that if the owners object after the additions are constructed, they will be told they are temporary and will be removed when the lease is terminated. Engineer Talaat supports this approach. This entire issue is difficult to evaluate. It would appear that the change from conventional to prefabricated aluminum design is a transparent attempt to rationalize the "temporary"

aspect of the additions. Removing conventional masonry structure at the termination of the lease would involve very little additional work over that required to remove an aluminum structure, especially when both would have permanent footings. In the U.S., the determining factor between temporary and permanent construction is usually the foundation. The decision has been made and should be implemented after the legal problem is resolved.

3.5 Recommendations for Future Actions on MCH Clinic Construction

The problems should be approached on a systematic basis. The following recommendations are intended to offer an identification of the problems by project (MCH clinic) site, suggestions and timetables for their resolution, and a program for isolating the problem areas so that the remainder of the construction can proceed.

3.5.1 Construction on Private Property

This is a legal problem that directly affects 5 clinics (Manshiat El Sadr, Al Zatoon, Badran, El Assal and Shoubra Awal). By inference, it affects 2 clinics (El Qalaa and Helwan Awal) and possibly the remaining privately-owned clinics. There is a general opinion that the additions are more likely to affect ownership than the internal renovation. Dr. Nabahat states that their attorney has given them a written legal opinion to the effect that MOH can remodel, make additions to, and rehabilitate the rented properties, and that these actions will not affect the lease. That legal opinion should be immediately reviewed by USAID Legal staff. Inasmuch as the contractors have already started the internal renovations, there would seem to be no reason for them not to continue. The external additions should not be started until USAID legal staff have reviewed this opinion and given their approval. If there is any reason to believe that the leases can be broken as a result of these additions, there should be an immediate reassessment. Therefore, it is most important that the MOH attorney's opinion be made available to USAID at the earliest possible time. If this determination cannot be made by 15 October 1982, these additions should be deleted from the contracts.

3.5.2 Temporary Clinic Locations

This problem seems to have been resolved except at El Fagaala and El Zawya El Hamra. This should be confirmed and all MCH Clinic locations where this problem is unresolved should be identified. I suggest that Alemara, USAID and the Project Staff all be represented in a committee to go to the zones and attempt to resolve the problem with the "shack" location or to secure a place for temporary operation of the clinic. If neither of these can be accomplished by 15 October 1982, the clinic renovation should be deleted from the contract and withheld for future contracting until the question is absolutely resolved.

3.5.3 Redesign of Additions.

As stated elsewhere in this report, the decision to redesign the additions to 5 of the rented properties in aluminum has not been implemented. USAID engineers and Alemara are now discussing this matter with the objective of determining the scope of this change and preparing a combined recommendation for Dr. Nibihat. The negotiation with the contractors should proceed immediately and be concluded so that work can begin as soon as the legal problem is resolved.

3.5.4 Building Permit at Ramlet Bulac

This construction has been suspended because a local official is insisting that MOH have a building permit to enclose a balcony. If this issue is not resolved by 15 October, I recommend that the portion of the work effected (i.e., the balcony) be deleted from the contract and the contractor be instructed to proceed.

3.5.6 Inability of MOH to provide unrestricted access to all clinics in a zone.

If the problems delineated above are resolved, or actions taken to remove problem areas from the contracts, the contractors will have unrestricted access to the remaining work. Assuming the worst situation, the contracts will be as follows:

Zone 1 Contract

<u>Clinic</u>	<u>Near Term - Action Contemplated</u>	<u>Probable Work Remaining</u>
Ramlet-Bulaq	Deletion of work to enclose balcony	All work except balcony.
Bulaq Awal	Deletion of exterior work affected by billboards	All work except windows and entrances.
El Musky	Completion of major redesign and negotiation with contractor	All negotiated work.
El Fagaala	Will be removed from contract if temporary operating spare is not found	Deleted.
El Sabtia	None	All original contract work.

This contract should not require amendment or renegotiation except for the El Musky work.

Zone 2 Contract

<u>Clinic</u>	<u>Near Term - Action Contemplated</u>	<u>Probable Work Remaining</u>
El Zawya El Hamra	None	All work in original contract.
Manshiet El Sadr	Negotiate aluminum addition pending legal opinion	All original work except for additions.
El Amerya	None	All original work.
El Sharabia	None	All original work.

Zone 4 Contract

<u>Clinic</u>	<u>Near Term - Action Contemplated</u>	<u>Probable Work Remaining</u>
Matariah	None	All original work.
Al Zatoon	Negotiate aluminum addition pending legal opinion	All original work except for additions.
Ain Shams	None	All original work.

Zone 5 Contract

<u>Clinic</u>	<u>Near Term - Action Contemplated</u>	<u>Probable Work Remaining</u>
Badran	Negotiate aluminum addition pending legal opinion	All original work except additions.
El Terra EI Boulakia	Deletion of clinic from contract if structural problem not resolved	None.
Al Assal	Negotiate aluminum addition pending legal opinion	All original work except additions.
Shoubra Awal	Negotiate aluminum addition pending legal opinion	All original work except additions.

3.5.8 Suggestions for Negotiations and Evaluating Clinics

As indicated in the discussions in paragraph 3.5.1 thru 3.5.6 above there may be some significant reductions in three of the four construction contracts. Particularly in the contracts for zones 3, 4 and 5. These reductions may involve more than 25% of the contract. If so, a new negotiation must be made with these contractors in compliance with the contract. Additionally there will be a renegotiation on the aluminum additions in the contracts for zones 3, 4 and 5 if we are to proceed with that work. As stated in paragraph 3.2, there are undoubtedly some pending claims for delays already encountered. The contractors should be requested to state in writing whether they intend to submit claims for delays up to this point. The amount and justification for each claim should be submitted for evaluation and negotiation. These matters should be resolved and not left to the end of the contract.

3.5.9 Staffing Recommendations

3.5.9.1 The concept of having A and E consultants to advise Dr. Nabahat (the Talaat Group) has not proved to be productive. The principal reason seems to be that their Scope of Work directly conflicts with the scope of work of the design consultants. It is my opinion that the USAID engineering staff should provide more assistance, and are in a better position to recommend actions to assist the implementation of the projects. This increased involvement is already being implemented and should supplant the need for other engineering advisors. Therefore I recommend that the position of A and E advisor to Dr. Nabahat be terminated. All vehicles, materials, reports or information in their possession from this contract should be returned to the project. This change should be implemented as soon as possible.

3.5.9.2 Alenara Company

This contract is about to expire. This company has discharged their duties quite well, and is almost inextricably involved with the project. My opinion is that it would be a serious mistake not to renew their contract. I recommend this be done without delay.

64

3.5.9.3 Additional Assistance for the Project

It is likely that in the near future, it will be obvious that the project will require an administrative position to assist in keeping project records, monitoring routine reports submissions, and information gathering of a non technical nature. The USAID project manager in consultation with USAID engineering and the Project Director may wish to consider this staff addition. I suggest the decision be temporarily held in abeyance and considered after the new system has had a chance to operate. (See attached proposed position description.)

4.0 Construction of General Urban Health Centers (GUHC's):

Eight GUHC's are to be constructed in the Cairo Area. DMJM/Kidde is the design consultant. The preliminary design and report was submitted in March 1982 and was approved by MOH. There has been some subsequent haggling over the amendment to the agreement principally between USAID and DMJM/Kidde. The amendment has now been approved by USAID (1 September 82) and an agreement has been signed between DMJM and Misr Engineers for local preparation of working drawings (7 Sept 82) Misr now has 3 months to prepare working drawings. The principal delay during this period has been caused by the USAID/DMJM/Kidde disagreement.

5.0 Construction of the Center For Social and Preventive Medicine:

DMJM/Kidde was given instructions to proceed on preliminary design in December 1981, and should have had their preliminary design complete in 4 months (April 1982). They have been delinquent on this work but now the preliminary design has been approved (August 24, 1982). There was some delay caused because the property survey was not obtained by the GOE until February 1982. This still makes the design 2 months late. Some of the delay must be placed with the GOE; however, most in the fault is of DMJM. DMJM expects to have the preliminary design report complete in December 1982.

65

Conclusions:

1. Alemara: This company seems to be discharging its duties very well. A project such as this (i.e. remodeling) always requires a significant involvement by the A & E during the construct phase. There are many problems and delays besetting these projects, however very few of them originate with the A & E and none of the major ones. There are some problems associated with reports, however these do not impact on the critical path.

2. MOH Consultant:

Advisor- Engr Talaat seems to be doing the work described in his contract "scope of work" satisfactorily. His CV does not indicate much background in the remodeling of buildings and in fact this seems to be his weakest area. It is unfortunate that he hasn't been able to solve any of the major problems and delays. He also seems to have considerable difficulty staying within the role of an advisor.

**Suggested
Scope of Work**

Intermediate Administrative Position

The incumbent will :

1. Determine the administrative actions and their due dates described in the various A & E contracts and monitor their completion; and note any delinquencies and provide the Executive Project Director with an appropriate monthly listing.
2. Attend monthly progress meetings.
3. Note outstanding actions from monthly progress meetings and their suspense dates; and keep regular records of their status for reporting to the Executive Project Director.
4. Assist in the coordination and follow-up of actions of other agencies or governmental units which impinge on the Project.
5. Serve as a special projects officer to handle routine matters associated with construction.

Qualifications: Incumbent should be a graduate of an accredited engineering school; and should be familiar with the Project and the procedures of the MOH. Incumbent should have at least 3 years administrative experience, particularly in relation to an external donor funded project.

ANNEX E

Special Evaluation of the
MCH Urban Health Delivery Systems Project
Social Scientist's Report on Project Activities in Cairo
Nawal El Messiri Nadim, Ph.D.

1. Introduction

This report was initially meant to discuss the impact of the project on its target groups. According to the project paper, the project is to "upgrade and modify the existing maternal child health and family planning delivery systems". The target group to be reached is women of child bearing age and children under 6 years of age.

In an initial meeting of the evaluation team, it was decided that at this stage of the project, partly due to the delay in the renovation activities, it is rather difficult to assess any impact of the project on the users, other than the fact that they now receive services in crowded temporary facilities. For purposes of evaluation at this phase of the project, therefore, the target groups are considered to be the providers of the services at different levels of the organizational structure. This report addresses four main issues which are considered to constitute the core of the evaluation of services at this particular phase:

- A. The providers' views of the project
- B. The extent to which awareness and understanding of the project's objectives and implementation plans are filtering down to personnel at various levels of the health services system.
- C. The project's relation to the existing MOH organization at central, governorate, zone, and facility levels.
- D. The problems encountered by the providers as a consequence of the temporary stage of renovation and their impact on the project.

The information presented in this report is based on personal observations of temporary centers and centers under renovation and on interviews with the following resource persons:

- A. Officials in the project's central office
- B. Officials at the Zone level of the Old Cairo Zone
- C. Personnel of four MCH Centers: Maadi, Helwan Public Housing, Old Cairo (all of which the project's Executive Director suggested to the consultant), and Ramlet Boulaq (selected independently by the consultant)
- D. The director and social worker of the project's pilot GUHC at Tora.

2. Social Analysis and Evaluation

This report aims at assisting the project's managerial staff to achieve the overall objectives of the project, by evaluating and assessing the present situation.

The project paper outlines four major components for upgrading the services in the urban MCH facilities of the MOH:

1. Improving services through renovating buildings will create better working conditions which eventually will have an impact on both users and providers of services.
2. Training and reeducation of providers is expected to improve their performance.
3. Improve and develop health services outreach and encourage community participation.
4. Devise systems for providing data and information required to plan, implement and evaluate delivery.

Those same components are followed in the remainder of this section of the Social Scientist's Report, followed by comments on lessons learned in the use of temporary facilities during renovation.

2.1 Renovation

The UHDP Executive Director and her staff put heavy emphasis on the impact of improving the physical structures of the buildings. Problems of construction, relocation to temporary centers, and the delay in construction consume a great deal of their time and energy.

Delays in renovations are creating negative repercussions on all aspects of the project which in turn are filtering down to all levels of providers and to the users of services. Furthermore, delays in renovations have become, sometimes unduly, the scape-goat for any shortcomings or deficiencies in the different aspects of plan implementation. For example, even shortages in outreach activities are attributed to renovations.

The project has its own conceptual frame for renovation which is well studied and planned. From the construction perspective, it is more practical and economical to seek standardization for renovation activities. However this could result in leaving little room for variations which are attributed to the social environment of each locality. Three such variations in social environments could be singled out.

- Centers located in public housing localities (seven centers).
- Centers located in traditional popular quarters.
- Centers located in peripheral areas.

It has been noticed that residents of public housing areas are often rough and have little concern about the physical structures in their neighborhood. The buildings are known to be public property and accordingly everyone has the liberty to use and abuse them. External open areas could be easily exploited. Under such conditions it is recommended that the centers be sheltered from the exploitation of the social environment. The center of Ramlet Boulaq presents a striking example where there is a need for the renovation process to assure the security of the providers. It becomes essential to have a separate entrance and to avoid large agglomerations of clients inside the building by, for example, orienting the pharmacy to the outside.

In traditional areas where neighbours have close knit ties, going to a clinic is considered to be a social activity*. (FOOTNOTE: *Check Evelyn Early's dissertation on MCH clinics in Boulaq.) Thus renovating the buildings on the basis of waiting areas for the sick and others might not always be acceptable to the local people.

In the centers located in peri-urban areas, more room is needed for the accommodation of "found" children. MCH centers in those areas receive more of these "found" children. Parents who abandon their children seek far and secluded places.

These are examples of some of the problems I have noticed which prompt me to recommend that in the process of renovation a certain amount of flexibility needs to be applied. The best source for depicting the characteristics of each locality are the personnel of the units themselves.

2.2 Training of Providers

Training programs for all components of the project have been devised. In general, trainees appreciate the training courses. Trainees showed more interest and involvement in the technical courses related to their specialization. However the idea of an interdisciplinary approach to the program has not filtered down to the trainees.

The general impression one gets is that the trainees are not putting the knowledge acquired to effective use. Presently they are presumed to be storing this information, waiting to put it into practice when the renovations are completed and they move back into the permanent facilities. It is true that certain aspects of the training could not be implemented in the temporary centers. However, tying the training that closely to the renovation raises certain questions:

- Is it possible to undertake an effective training program without renovation?
- How long could the trainees retain the information without practicing it?
- What will be the situation if there are further delays in renovations?
- Will there be a need for a refresher courses?

70

Although trainees' responses to the training are collected before and after attending the courses, it is extremely important to have a systematic evaluation of the impact and utilization of the training on the trainees even before they move to their renovated centers.

2.3 Outreach and Community Participation

Tools for implementing outreach activities, such as questionnaire formats for midwives, traditional birth attendants and users characteristics have been devised. However, outreach activities of midwives and assistant midwives have decreased in the temporary centers. Also, very few outreach activities are undertaken by the social workers. A major outreach activity that is taking place is that of locating host families for "found" children. The pilot GUHC at Tora has experimentally done some health education outreach activities through the health educator. These activities were hampered by delay in arrival of health education materials and equipment such as projectors and handouts.

It is recommended that outreach activities need not wait until the renovations be complete; on the contrary, outreach activities need to be intensified at this stage to make up for the shortcomings of the temporary centers.

2.4 Data and Information Systems

Data compilation needed for planning, implementation and evaluation is not yet established

Recording, storage and retrieval of data at the temporary centers is next to impossible due to shortage of space and facilities. This leads to losing important information which could be used for planning and implementation. For example, centers complain of loss of clients due to the renovation. However not a single center could supply me with figures to support such an argument.

Social workers and health educators keep records of the dates and numbers of their home visits, and supervisors are supposed to check these records. No monitoring or evaluation techniques have been devised to check the content of the outreach activity or its effects on the community.

Similarly, techniques for evaluating the trainees' work in their centers have not been devised. The criteria for such evaluations need to be selected.

At the central level all components of the project are considered to be equally important; there is a clear understanding that each component feeds back into the others. It seems, however, that at this stage of implementation certain components receive more emphasis and attention than the rest. Renovation ranks first and training ranks next, leaving outreach activities and data compilation with minimum attention.

This ranking does not necessarily reflect priorities of the project but rather reflects consumption of time and energy of officials at the central level.

Theoretically channels of communication are to flow from the central office of the project to the zone and from there to the MCH centers.

Information about the project and its objectives is filtering down all levels, but the various messages are received differently by the different levels and different centers. The reactions vary from enthusiasm to indifference or suspicion.

The project is the main and only job of the officials at the central office. Their future career and reputation depends on its success, therefore they exert every effort to make it successful.

Unlike the officials of the central office, the officials of the zone offices have numerous other responsibilities besides the project. To them the project means more work. They are responsible for implementing, supervising and evaluating the project as part of their routine work. They are the least to benefit financially from the project, though they are the ones who will be finally responsible for maintaining and continuing the services in the centers, especially after the end of the project. Given all these circumstances, one could not expect them to be very enthusiastic about the project.

Personnel of the centers are in an ambivalent situation. They feel that they are the beneficiaries of the project, yet their power, future and reputation depend both on their zone directors and on the neighborhood they serve. Zone directors control distribution of positions and promotions, while the neighborhood supplies them with extra income -- through giving access to private patients.

Clinic staff members believe that the project will lead to better working conditions, which they like, but it is still questionable whether the improvements will lead to increase of income. Many of them are indifferent and skeptical about the project.

2.5 Lessons Learned from the Renovation and Use of Temporary Facilities

- Time given to renovation should be realistic and fixed. Many problems could have been eliminated if the renovations were completed in time.
- Temporary facilities do not necessarily mean inconvenient facilities and inhuman conditions, which ultimately have negative impacts on the MOH and the project. Renovation without moving to temporary facilities also proved to be inconvenient.
- Personnel of the centers should have more input in the renovation.
- Personnel of the centers often have certain interests which are not necessarily the best for the project.
- The Social environment should be accounted for in the renovation.
- Before moving to temporary facilities an implementation plan should be developed for the transitional period, including outreach activities.

3. Results of Interviews with Providers and Managers of Health Services

3.1 Responses of Officials in the Urban Health Project's Central Office

At the central office interviews and discussions were carried with Dr. Nabahat Fouad (Executive Director), Dr. Eng. Ibrahim Karim (A & E Contractor), Dr. Ensaf Hanna (Head of Training Research & Development), and Mrs. Ikhbal Hanna (Head of Social Services).

There is consensus among this central office group that evaluation of the impact of the project on the users and on the personnel of the MCH would be premature at this time. They believe that the impact of the project is very much dependent on completion of the construction phase, and prior to that they expect no changes in attitudes or services. On the contrary, during renovation they expect to find deteriorated services and little enthusiasm, due to the inconveniences of the physical settings of the temporary MCH centers.

All project personnel at the central level are extremely enthusiastic about the project. They feel that a great amount of thinking, research, planning and energy, as well as money, has been invested in the project. They believe, however, that the temporary stage could have been smoother if the project had provided large mobile centers to accommodate the services.

The A & E contractor and the executive director differentiate between renovation and upgrading of MCH centers. Renovation could mean just cleaning and repairing the physical structures of the centers. Upgrading, in their view, involves a wider spectrum of activities. A & E Contractor Engineer Ibrahim Karim expressed enthusiastically that prior to reconstruction of the centers many resource bodies and individuals were consulted. At one point a committee composed of representatives from USAID, Westinghouse, Project Staff, and the MCH (Dr. Lutfy El Sayyad) discussed the flow, circulation and interrelationships of activities in the MCH facilities and how to incorporate them in the remodelling. (Note: There were about 20 sub-committees.)

In response to my question as to the involvement of the MCH personnel in the planning of the remodelling, Dr. Karim said that the communication was a two-way process. After the above committee set the conceptual frame for the remodelling, field staff (including directors of zones and MCH centers, social workers, pharmacists, and dentists) were given a chance to each discuss specific problems related to their areas of specialization. Also when the remodelling plan for each center was put on paper they were again consulted and the centers' directors were asked to sign the model plan.

Dr. Nabahat and Dr. Karim explained to me the logic and philosophy behind the different concepts in the remodelling process, such as the separate flows of circulation of the sick and the healthy, utilization of waiting spaces, interrelationships of activities, heating and cooling, and cleanliness and sanitation. When I asked if the personnel in MCH centers are aware of the details and explanations given to me, I was told that the centers' personnel are not aware of many of these details because it is beyond their imagination to believe that such a change will take place. They have to see it happening and existing so as to believe it.

Furthermore, Dr. Nabahat and Dr. Karim believe that it is very difficult to please the personnel at the health facilities. Dr. Karim recorded on a video tape the condition of the centers prior to the remodelling. He is ready to show it to personnel who complain about the improvements of the centers because he feels that "They are always jealous and suspicious of other officials". Dr. Nabahat attributes this attitude to the salary scale. They both doubt that the project will be fully successful if it is not accompanied by an incentive system.

Development of the human resources for upgrading services consists essentially of training programmes.

The director of training, Dr. Ensaf Hanna, is full of enthusiasm for the training programs. Training programs for all components of the project have been devised. Dr. Ensaf sees the role of the central office in training to be one of planning and program development. The officials in the central office depend heavily on inputs from zone officials. The zone authorities have to supply the central office with the number and specialization of personnel in each level, to permit the central office to arrange and plan for the number of workshops and the number of participants in each. Once this is established the zone officials are to supply the central office with the names and job titles of the selected participants.

The central office then conducts the training courses at central or zone facilities. The central office considers itself responsible for evaluating the training program through testing the level of knowledge (and skills?) of the participants before the course and immediately after finishing. The central office does not conduct any on-the-job evaluation of training participants in the centers where they work. The Training Director feels that this should be instead the responsibility of the zone officials, who should play a more active role in supervising, monitoring and evaluating the MCH personnel. There is some informal follow up, by central office officials, of personnel who attended training courses, but no materials and no formal or systematic method for on-the-job evaluation has been developed by the central office. There is a need, of which the central office staff is aware, to develop criteria for evaluation of the trainees.

Dr. Insaf of the central office believes that the personnel of the MCH have profited from the training courses, that they have gained additional knowledge, but that this knowledge is not yet internalized to allow it to come out spontaneously. She thinks that this might be attributed to the fact that the present physical setting does not encourage change and believes that once the trainees move to the renovated centers they will utilize the information they acquired from the training courses.

At the central office, the outreach component of the project is exemplified by the plans of the Information, Education and Communication Unit. These are considered to be the domain of the social worker, who collaborates with the training unit and attempts to provide them with relevant information needed for the development of the training programs. For the purpose of the outreach component, the following activities have been accomplished in the central office.

Two interviewing formats have been developed to assess the knowledge of the midwives and the traditional birth attendants. (Very few cases have been interviewed to date.) A third format was designed for the MCH users.

Messages for breast feeding, environmental sanitation, diarrheal diseases and rehydration have been developed.

Programs for home visiting and participation of community leaders are also developed as part of the outreach component.

Though Mrs. Ikbal mentioned that she works through the zone officials, she herself took IECU Programs to each of the health centers of the project areas and introduced the social workers of the centers to them so that they can use them to provide service users and community members with health education. Mrs. Ikbal feels that up to now social workers are not leading any group discussions and that if they do any health education at all it is on an individual basis. Community participation activities have taken place only in the project pilot GUHC center at Tora, because it is the only center which has health educator.

3.2 Responses of Officials in the Zone of Old Cairo

Officials at the zone level believe that the project staff in the central office are only responsible for planning, and that they at the zone level are the ones who must face the problems of implementation. The major problem that they are having is solving the inconveniences which resulted from the temporary centers. As a consequence of crowding, the personnel of the centers are in a constant state of disagreement - no one is satisfied - and many patient records are lost. Many activities such as circumcision, inpatient clinics and IUD insertion have been disrupted due to shortage of space. Storage of food and medicine has become problematic. Centers which were moved to temporary locations far from the original facilities now serve fewer clients. It took even those clients some time to find the new centers.

Officials interviewed in the zone do not think very highly of the effectiveness of the training programs. The technical training will not help the participants financially, and the training for administration is not necessarily useful. The training is not useful or applicable after the training course is completed. The following statement was made by the Old Cairo Zone's Director of MCH: "No matter how many training courses are given, how do you expect to change the personnel's performance when you are overburdening them with extra work such as filling out questionnaires and at the same time giving them no incentives or extra salary?"

The zone's MCH Director also feels that the MCH personnel are the least privileged officials in the MOH because they do not have the financial advantages of offering "economic treatment". (Dr. Nababat informed me that the project is considering the possibility of initiating "economic treatment" in the MCH centers, but zone personnel do not know this.) MCH centers suffer from shortages of staff because they do not have access to incentives (as do for example, hospital personnel).

Officials of the zones are responsible for nominating participants for in-country and out-of-country training programs. Change of personnel in the centers is a major obstacle in that area of training. Many of the medical doctors who had been trained for the project have now left the project centers, and many of the present staff know little about the project.

3.3 Responses of MCH Personnel

Four MCH Centers were visited. The Maadi, Helwan, and Old Cairo Centers, visited at the direction of the project's executive director, are located in neighborhoods atypical of those served by the MOH facilities, because they have relatively higher incomes. The fourth center, Ramlet Doulaq, is located in neighborhood more typical of MOH facilities found in public housing, and the situations, frustrations, and problems noted by the center's director are probably more typical of those faced in such centers.

3.3.1 Maadi Center

The Maadi Center which is presently undergoing remodelling is a villa located on an elegant and fairly quiet street. The temporary center is four or five streets away. Because the director of the center was concerned that the clients find their way to the temporary location, a poster indicating the address of the temporary location was left on the gate of the permanent Maadi Center. Furthermore, the director of the center assigned one of the male attendants to remain at the renovation site to direct the clients to the new location. In spite of these measures, the director noticed a drop in the number of clients after moving to the temporary center.

The personnel of the Maadi Center as a group discussed with me the problem of space in the temporary center. At the temporary location, two rooms must accommodate 24 staff members and the clients. One room is used by the medical doctors, the pharmacist and the social worker. The other room is used by the nurses, assistant midwives, and attendants during the day. In the evenings the assistant midwives of the night shift use it to sleep and to receive emergency cases until they are transferred to the hospital. "Found" (abandoned) children are placed somewhere in the two rooms until a host family receives them. The corridor and the entrance are used for meeting clients, insertion of IUDS, examination of the sick, and distribution of drugs and foods. The director of the center feels that this crowded condition did affect the number of clients coming to the center.

As a consequence of shortage of space, no inpatients are received for deliveries in the temporary center. All cases in labor are referred to the hospitals. This also reduces the number of clients.

The temporary center does not have access to a car to take the assistant midwives into the community for home deliveries. The director of the center says that there has been a reduction in the number of births delivered through the center. Midwives and assistant midwives have been accepting and engaging personally in deliveries at clients' homes, for money. In the temporary center, health education and kitchen demonstrations have stopped completely. 76

The outreach activities of the social worker are limited to finding nursing mothers and finding host families for the found children.

The medical personnel of Maadi center believe that the renovation will lead to better service. However the director of the center considers that real change in performance is feasible only if the director has the power of punishment and reward. The personnel believe that incentives are important, but that even without them the renovations will lead to changes in services.

Medical personnel think that the training courses were useful, though some of them were repetitious (e.g. rehydration) both within courses and from one course to another. The director of the center believes that the courses given to the nursing staff raised their level of knowledge but not their performance and that without her strict supervision they do not practice what they were taught.

The director of the center accompanied me to the construction area. We went through all the rooms and she pointed at what she considers to be weaknesses in the plan. She was very much opposed to having the dentist's room on the second floor, especially in the absence of a waiting area on that floor. She expressed her fear that dental clients will sit on the stairs and hinder the movement of the other clients. The director also doubts the durability of the wooden stairs under heavy use. She asked me to convey her remarks to the central office of the project. She feels that she is more aware of the daily problems of the center and should have been consulted about the remodeling of the center. (I was informed latter by Dr. Karim that the second floor has a large waiting room. The director of the center considers this room to be her office.)

3.3.2 Helwan Public Housing Center

The Helwan Center which is undergoing construction is a one-story building with an open space surrounding it. It is located in the market area of the public housing. Due to renovation this MCH center is hosted in the building of the Medical Center of Helwan which is located in the midst of the public housing, but three kilometers away from the Helwan Center.

First I met the director of the host center. I asked him if the presence of the temporary center is creating any problems for his center. He said that two rooms of his spacious center have been assigned to the temporary center. They have their own entrance, and the temporary center has little impact on the services of the host center. I visited the area allocated to the temporary center. The two rooms had at least 100 women and children crowded into them. Many services were simultaneously going on, and cholera vaccinations were administered on the stair-case. Pregnant mothers were waiting for their monthly check up. Sick children were being examined, and someone, somewhere, was handing out medicines to the clients.

In spite of the crowds, the director of the center being remodelled knows that he lost many of his clients due to the renovation. However, he is very happy with the new center but does not know why he can not yet move to it. He showed me the condition of stored furniture of the center. He thinks that the furniture is now not good enough to be repaired, but project officials say that it has to be repaired and used. The doctor feels that it will take months to repair it and that even then it will be no good. He feels very depressed and frustrated because he knows that his center is almost ready but that the problem of the furniture will further delay his moving. He asked me to carry his request to Dr. Nabahat because he finds it very difficult to arrange meetings with her.

Like the director of the Maadi Center, the director of the Helwan Center is also dissatisfied with the location of the dentist's room. He says that this room is the only one that has a window overlooking the open space in front of the building. This room could be used as a pharmacy so as to avoid the crowding of the pharmacy clients inside the building.

3.3.3. Old Cairo Center

Like the two previous centers, this center also suffers from shortage of space in the temporary center. In this center I had the opportunity to speak to the social worker. She has a very clear understanding of the objectives of the project. She said that the renovation aims at improving the services; it is not only painting and improving the physical structure, but also making the services more accessible to the users and the jobs more pleasing for the providers. The organization of the clients and their circulation in and out of the center will also create a more relaxing atmosphere.

The social worker also feels that the training programs would definitely help the workers improve their performance. She benefited a lot from the training programs. Courses on contagious diseases, vaccination, and sterilization were very useful to her, especially when doing home visiting and during the health education sessions that she gives to the clients. There was one training course which she did not profit a lot from: that was the course which social workers shared with the assistant midwives. In this course there was detailed information about the midwifery kit, the preparation of the labor room, and similar issues which were rather irrelevant to the social workers. She also felt that the assistant midwives attending the training were not serious, and she doubts that they benefited from the program.

At one point the social worker and other members of clinic were consulted about the remodeling of the center but they have noticed very little change to date.

The social worker felt that the users do not know much about the project, and she has not been doing any outreach activities. However she gives some health education to the waiting clients, based on ideas she has acquired during the training programs. She never received any systematic lectures. She develops her own speeches. She used to perform these activities more regularly at the original center.

The director of the center was very pessimistic about the project. She said that she knows nothing about the project and therefore cannot predict whether the renovation will improve the services or not. She was furious that she still does not know when the renovation will be completed. She is also angry because she feels that all of the remarks and ideas that she gave to the project about the remodeling were never taken into consideration.

3.3.4. Ramlet Boulaq Center

At this center I was able to interview the director, the social worker, the pharmacist, the clerk, one of the assistant midwives, and the messenger.

The permanent facility of the MCH Center of Ramlet Boulaq occupies the first floor of three adjacent buildings of the public housing of Ramlet Boulaq. The neighborhood and the whole environment is a very poor one. The temporary center occupies a two room apartment for the clinic and another similar apartment for the residence of night shift assistant midwives. The temporary center is facing the main center.

The renovation in this center is still at a very early stage. The construction did start, but nothing has been happening for months and the apartments are deserted and used by street peddlers and passers-by as a resting place.

The knowledge and views of the messenger, the clerk, and the assistant-midwife about the project are summarized in two points. One is that the Americans will renovate the center to make it similar to American health centers. Second, the renovated center will have "economic treatment". They expressed that this is what they heard about the project and consider it to be a dream that might not come true.

The social worker said that the project aims at extending the services so that the clients will not need to go out of the district for health services. The project will also give the clients new cards on which they could follow the health status of their children. Furthermore, the waiting area will have chairs which will be marked with different colors; those coming to the dentist will use certain chairs, pregnant mothers use other chairs, etc. The social worker got most of her information from the T.V. program that Dr. Nabhat broadcast recently.

The social worker attended three training programs which she thinks will be useful to her if she changes her specialty. For example, the program on school health education would be of value to her if she decides to leave the MCH and work as a social worker in school health education.

The social worker mentioned that she is not giving the users any information about the project because she herself does not have a complete picture about the project. She does not even know when the renovation will be complete.

The clerk is responsible for the stores and the records of the center. Both the records and the furniture and equipment of the center have been stored somewhere in Manial. The clerk does not know what happened to these items in the process of moving them, nor does she know the condition that they are in now. In spite of that, the bureaucracy requires that annually she present to the zone a list of the items in her possession. This situation is scaring her.

The director of the center is very pessimistic about the project. He thinks it is a waste of time. "Planners of the project are sitting in the fourth floor in an ivory tower they have never lived the problems that we are facing in Boulaq. Do they know that we are living in the middle of narcotic dealers and thieves? Do they know that everything in the center was robbed and the next day everything was returned? Do they know that one of the 'found' children was stolen from the center? Do they know that I cannot keep alcohol in the center? Do they know that one of the peddlers uses the center at night to sleep in and I cannot object? These are my problems. Instead of helping me find solutions for them, Dr. Nababat says that the project is going to install "Lecico" bathrooms in the center and the center will have one entrance for the healthy and another for the sick."

Given this physical and social environment of the Boulaq center, the director feels that it has been totally erroneous to renovate the center, which occupies apartments in the public housing. He has no control over the neighbors. Even if the place is renovated he cannot stop the neighbors from throwing garbage on his center, nor could he control the water leakage from the upper floors. The doctor thinks that the best solution would have been to construct a new center with a separate entrance. Barring that, the director had suggested that the project renovations install a separate rear entrance to the center, to diminish conflicts with the inhabitants of the public housing in which it is located. (This is a major problem, which has led to popular expulsion of MCH centers from other government-owned public housing facilities, as was the case at the MCH center in the public housing facility at El Asial visited by other members of the evaluation team.) His suggestion was ignored, which leads the director to be even more pessimistic about the center's future acceptance by the community and renders him furious.

The director, in summary, feels that under present plans three months after the renovations were completed no one would notice the changes anymore.

To improve the performance and the service in this center, the director feels that he should be given more power over the staff. At present he feels that most of the present staff have formed exploitative relationships with the community and that they sell their services. He wants to have the power to change the staff and to recruit new members and give them incentives so as to perform their jobs honestly and well.

The director of the Boulaq MCH Center found the training courses on medical-technical aspects of the centers work to be useful, was interested in them, and attended them regularly. Other courses, such as those on administration and work problems, were irrelevant because they never presented solutions to the problems.

3.4 Responses of providers at the Tora GUHC

Tora GUHC

Tora Center is the project's pilot demonstration center. It is located in a less densely populated area. The center itself is spacious and allows for potential innovations which could be difficult to replicate in other centers having less room and serving larger populations.

Personnel of the center feel that the renovation has been extremely inconvenient. They keep moving their offices, papers and equipment from one section of the building to another. The construction dust and materials are messing the whole place. It is very difficult to clean the place.

The acting director of the center believes that the training courses on the whole were useful, especially those related to emergencies and sterilization. Training related to strengthening managerial and administrative capabilities on the other hand, is difficult to grasp without practical implementation on the centers' files, which is not feasible at this stage.

Of all the facilities in the project, Tora is the only one which has a health educator. The health educator tried to have several meetings with community leaders. It was possible for him to accomplish this last because he is a resident of Tora and was brought up in the area. He organized monthly meetings. One meeting was on Rat control and others were on sanitation in general. He promised community members that he would show them films but was not supplied with film or projection equipments. In every meeting he kept promising the residents improvements in services as a consequence of the renovation. Now it is embarrassing for him to undertake such meetings, because the promised improvements have not occurred.

ANNEX F

Action Timetable and Responsibilities Chart
for the Major Events in the
Urban Health Delivery Systems Project

Ministry of Health

<u>Responsible to:</u>	<u>DUE DATE</u>
1. Extend Alemara contract	11 Oct. 82
2. Officially assign counter- parts to Westinghouse equipment specialist	20 Oct. 82
3. Review plans/budget require- ments to extend services and training to the North and East Zones	24 Oct. 82
4. Complete action on Continu- ation ECTOR Assistance	25 Oct. 82
5. Establish procedures/schedule for monthly joint Cairo/ Alexandria meetings	1 Nov. 82
6. Establish and fill inter- mediate position for non- technical support to the Executive Project Director on renovation/construction	1 Nov. 82
7. Reorganize UHDSF Central Office -construction/renov- novation	7 Nov. 82
8. Establish procedures for basic planning, tracking and management tools. Determine requirement/timing for Egyptian and/or ex- patriate planner	15 Nov 82
9. Complete review of MCH equipment requirements and initiate procurement	20 Nov. 82
10. Hold first Cairo/Alex joint meeting	1 Dec 82
11. MOH recertify the avail- ability of full time staff for Alex	1 Dec. 82

12. Reorganize UHOSP General Office - Health Systems 31 Dec. 82
13. Finalize and begin using tracking and management tools for UHOSP office, including hiring of planner as needed 31 Dec. 82
14. Finalize implementation plan, taking into consideration the evaluation report findings especially in reference to service improvements 31 Dec. 82
15. Complete necessary initial review of GUHC equipment requirements; initiate out of country procurement for those items that can be identified before design work completed 31 Dec. 82
16. Begin three-week Special Evaluation of the CSFM 11 Jan. 82
17. Complete detailed action plan for Alex 17 Jan. 83
18. Develop plans for staff functions during the renovation phase in Alex 31 Jan 83

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72

- 3F -

USAID

<u>Responsible to:</u>	<u>DUE DATE</u>
1. Begin DRPS (Engineering) direct involvement in renovation/construction in coordination with UHDP staff	4 Oct 82
2. Send letter to UHDP to extend Alexara contract	7 Oct 82
3. Forward letter to UHDSF requesting that all external work on MCHs cease and requesting legal back-up for this work and internal work in privately owned buildings	7 Oct. 82
4. Forward letter to Alex UHDSF requesting legal documents for AID certification that renovation work can proceed unhindered in leased buildings (4)	10 Oct. 82
5. Send letter to Alex UHDSF Director requesting comments on staffing (lack of "full time," and anticipated needs	17 Oct 82
6. Forward Evaluation Report to the MOH	1 Nov. 82
7. Review and take necessary action on extending activities to the North and East Zones	7 Nov. 82
8. Send letter to UHDSF on organization, requesting comments	8 Nov 82
9. Review Alex comments and prepare and forward PIL if necessary stating AID's position that no renovations funds will be released until assurances are received received that "full time", staff is available per P.A.	10 Nov. 82
10. Review reorganization comments by UHDSF and prepare PIL for implementation	23 Nov. 82

84

ANNEX G

Note for Team Evaluating the Center for Social and
Preventive Medicine in January 1983, from the
September 1982 Special Evaluation Team

The CSPM's organization and activities should be directed clearly toward accomplishment of the stated objectives of the CSPM and those of the UHDP. Examples of some means of promoting this include:

Active involvement of MOH officials in the CSPM's planning, management, and operations (including teaching).

Active participation of Cairo University officials of the CSPM in MOH facility operations as on-site consultants in medical and technical areas.

Joint MOH/Cairo University appointments for MOH and university personnel involved in CSPM activities.

Immediate actions to assure that the CSPM will be able to open and implement, with full Cairo University-MOH collaboration, a full and appropriate program of training, service, and (to a lesser extent) research activities.

Development of the GUHC at the CSPM (a "model" GUHC, as the university sees it) within the resource constraints and guidelines within which the other GUHCs of the MOH must operate.

Sharing (two-way) of experience and information with other related programs, activities, and projects (e.g., SCU/FCM, DDC, Assiut HIN, or other AID-supported projects, HIO, etc.).

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